..... moves to amend H.F. No. 2128 as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

DHS HEALTH CARE PROGRAMS

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

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

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

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

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

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

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

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

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

62Q.02 APPLICABILITY OF CHAPTER.

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

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

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

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

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

Subd. 3. **Other standards; wheelchair securement; protected transport.** (a) A special transportation service that transports individuals occupying wheelchairs is subject to the provisions of sections 299A.11 to 299A.17 concerning wheelchair securement devices. The commissioners of transportation and public safety shall cooperate in the enforcement of this section and sections 299A.11 to 299A.17 so that a single inspection is sufficient to ascertain compliance with sections 299A.11 to 299A.17 and with the standards adopted under this section. Representatives of the Department of Transportation may inspect wheelchair securement devices in vehicles operated by special transportation service providers to determine compliance with sections 299A.11 to 299A.17 and to issue certificates under section 299A.14, subdivision 4.

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For rate setting periods after November 1, 2014, in which the base

years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals.

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

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

(e) For discharges occurring on or after November 1, 2014, the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

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

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

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

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

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year or years and the next base year or years. In any year that inpatient claims volume falls below the threshold required to ensure a statically valid sample of claims, the commissioner may combine claims data from two consecutive years to serve as the base year. Years in which inpatient claims volume is reduced or altered due to a pandemic or other public health emergency shall not be used as a base year or part of a base year if the base year includes more than one year. Changes in costs between base years shall be measured using the lower of the hospital cost index defined in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per claim. The commissioner shall establish the base year for each rebasing period considering the most recent year or years for which filed Medicare cost reports are available. The estimated

change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

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

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

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

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

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

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

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

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

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

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

(6) geographic location.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(f)~~ (g) An additional payment adjustment shall be established by the commissioner under this subdivision for a hospital that provides high levels of administering high-cost drugs to enrollees in fee-for-service medical assistance. The commissioner shall consider factors including fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, or if the hospital qualifies for the alternative payment rate described in subdivision 2e, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed ~~$1,500,000~~ $9,000,000.

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

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

Subdivision 1. **Appeals.** A hospital may appeal a decision arising from the application of standards or methods under section 256.9685, 256.9686, or 256.969, if an appeal would result in a change to the hospital's payment rate or payments. Both overpayments and

underpayments that result from the submission of appeals shall be implemented. Regardless of any appeal outcome, relative values, Medicare wage indexes, Medicare cost-to-charge ratios, and policy adjusters shall not be changed. The appeal shall be heard by an administrative law judge according to sections 14.57 to 14.62, or upon agreement by both parties, according to a modified appeals procedure established by the commissioner and the Office of Administrative Hearings. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

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

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

256.983 FRAUD PREVENTION INVESTIGATIONS.

Subdivision 1. **Programs established.** Within the limits of available appropriations, the commissioner of human services shall require the maintenance of budget neutral fraud prevention investigation programs in the counties or tribal agencies participating in the fraud prevention investigation project established under this section. If funds are sufficient, the commissioner may also extend fraud prevention investigation programs to other counties or tribal agencies provided the expansion is budget neutral to the state. Under any expansion, the commissioner has the final authority in decisions regarding the creation and realignment of individual county, tribal agency, or regional operations.

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

be approved, to include any changes directed or negotiated by the commissioner, no later than June 30 of each year.

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

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

(b) The commissioner will maintain program compliance if for any three consecutive month period, a county or tribal agency fails to comply with fraud prevention investigation program guidelines, or fails to meet the cost-effectiveness standards developed by the commissioner. This result is contingent on the commissioner providing written notice, including an offer of technical assistance, within 30 days of the end of the third or subsequent month of noncompliance. The county or tribal agency shall be required to submit a corrective action plan to the commissioner within 30 days of receipt of a notice of noncompliance. Failure to submit a corrective action plan or, continued deviation from standards of more than ten percent after submission of a corrective action plan, will result in denial of funding for each subsequent month, or billing the county or tribal agency for fraud prevention investigation (FPI) service provided by the commissioner, or reallocation of program grant funds, or investigative resources, or both, to other counties or tribal agencies. The denial of funding shall apply to the general settlement received by the county or tribal agency on a quarterly basis and shall not reduce the grant amount applicable to the FPI project.

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

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

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

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

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

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

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

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

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

(4) dental claims processing;

(5) coordination of dental care with other services;

(6) management of fraud and abuse;

(7) monitoring access to dental services;

(8) performance measurement;

(9) quality improvement and evaluation; and

(10) management of third-party liability requirements.

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

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

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

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

~~The rules shall provide:~~

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

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

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

~~(c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective on January 1, 1981, "recognized provider of transportation services" means an operator of special transportation service as defined in section 174.29 that has been issued a current certificate of compliance with operating standards of the commissioner of transportation~~

~~or, if those standards do not apply to the operator, that the agency finds is able to provide the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized transportation provider" includes an operator of special transportation service that the agency finds is able to provide the required transportation in a safe and reliable manner.~~

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

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

(1) eyeglasses;

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

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

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

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

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

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

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

(6) drugs.

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

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

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

Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid for a pregnant woman who meets the other eligibility criteria of this section and whose unborn child would be eligible as a needy child under subdivision 10 if born and living with the woman. In accordance with Code of Federal Regulations, title 42, section 435.956, the commissioner must accept self-attestation of pregnancy unless the agency has information that is not reasonably compatible with such attestation. For purposes of this subdivision, a woman is considered pregnant for ~~60~~ 180 days postpartum.

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

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

Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the ~~60-day~~ 180-day postpartum period to update their income and asset information and to submit any required income or asset verification.

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

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

(d) The commissioner shall utilize information obtained through the electronic service established by the secretary of the United States Department of Health and Human Services and other available electronic data sources in Code of Federal Regulations, title 42, sections 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish standards to define when information obtained electronically is reasonably compatible with

information provided by applicants and enrollees, including use of self-attestation, to accomplish real-time eligibility determinations and maintain program integrity.

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

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

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

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

Subd. 3. **Qualified Medicare beneficiaries.** (a) A person ~~who is entitled to Part A Medicare benefits, whose income is equal to or less than 100 percent of the federal poverty guidelines, and whose assets are no more than $10,000 for a single individual and $18,000 for a married couple or family of two or more,~~ is eligible for medical assistance reimbursement of Medicare Part A and Part B premiums, Part A and Part B coinsurance and deductibles, and cost-effective premiums for enrollment with a health maintenance organization or a competitive medical plan under section 1876 of the Social Security Act~~.~~ if:

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

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

(3) the person's assets are no more than (i) $10,000 for a single individual, or (ii) $18,000 for a married couple or family of two or more; or, when the resource limits for eligibility for the Medicare Part D extra help low income subsidy (LIS) exceed either amount in item

(i) or (ii), the person's assets are no more than the LIS resource limit in United States Code, title 42, section 1396d, subsection (p).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

(viii) rehabilitation services;

(ix) physical, occupational, or speech therapy;

(x) transportation services;

(xi) case management;

(xii) prosthetics, orthotics, durable medical equipment, or medical supplies;

(xiii) dental services;

(xiv) hospice care;

(xv) audiology services and hearing aids;

(xvi) podiatry services;

(xvii) chiropractic services;

(xviii) immunizations;

(xix) vision services and eyeglasses;

(xx) waiver services;

(xxi) individualized education programs; or

(xxii) chemical dependency treatment.

(i) Pregnant noncitizens who are ineligible for federally funded medical assistance because of immigration status, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and ~~60~~ 180 days postpartum, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program.

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

of financial responsibility prior to providing mental health targeted case management services for those clients.

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

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

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

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

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

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

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

Subd. 3c. **Health Services ~~Policy Committee~~ Advisory Council.** (a) The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a ~~13-member~~ 14-member Health Services ~~Policy Committee~~ Advisory Council, which consists of ~~12~~ 13 voting members and one nonvoting member. The Health Services ~~Policy Committee~~ Advisory Council shall advise the commissioner regarding (1) health services pertaining to the administration of health care benefits covered under ~~the medical assistance and MinnesotaCare programs~~ Minnesota health care programs (MHCP); and (2) evidence-based decision-making and health care benefit and coverage policies for MHCP. The Health Services Advisory Council shall consider available evidence regarding quality, safety, and cost-effectiveness when advising the commissioner. The Health Services

~~Policy Committee~~ Advisory Council shall meet at least quarterly. The Health Services ~~Policy Committee~~ Advisory Council shall annually ~~elect~~ select a ~~physician~~ chair from among its members~~,~~ who shall work directly with the commissioner's medical director~~,~~ to establish the agenda for each meeting. The Health Services ~~Policy Committee shall also~~ Advisory Council may recommend criteria for verifying centers of excellence for specific aspects of medical care where a specific set of combined services, a volume of patients necessary to maintain a high level of competency, or a specific level of technical capacity is associated with improved health outcomes.

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

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

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

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

(4) the development of dental delivery models; and

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

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

~~(d)~~ (c) The Health Services ~~Policy Committee shall~~ Advisory Council may monitor and track the practice patterns of ~~physicians providing services to medical assistance and MinnesotaCare enrollees~~ health care providers who serve MHCP recipients under fee-for-service, managed care, and county-based purchasing. The ~~committee~~ monitoring and tracking shall focus on services or specialties for which there is a high variation in

utilization or quality across ~~physicians~~ providers, or which are associated with high medical costs. The commissioner, based upon the findings of the ~~committee~~ Health Services Advisory Council, ~~shall regularly~~ may notify ~~physicians~~ providers whose practice patterns indicate below average quality or higher than average utilization or costs. Managed care and county-based purchasing plans shall provide the commissioner with utilization and cost data necessary to implement this paragraph, and the commissioner shall make ~~this~~ these data available to the ~~committee~~ Health Services Advisory Council.

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

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

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

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

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

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

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

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

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

(b) Members of the Health Services ~~Policy Committee~~ Advisory Council shall not be employed by the ~~Department of Human Services~~ state of Minnesota, except for the medical

director. A quorum shall comprise a simple majority of the voting members. Vacant seats shall not count toward a quorum.

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

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

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

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

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

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

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

(3) limited exams;

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

(5) periapical x-rays;

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

(7) prophylaxis, limited to one per year;

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

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

(10) anterior fillings;

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

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

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

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

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

(16) nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies. By March 1 of each year, each 340B covered entity and ambulatory pharmacy under common ownership of the 340B covered entity must report to the commissioner their reimbursements for the previous calendar year from each managed care and county-based purchasing plan,

or the pharmacy benefit manager contracted with the managed care or county-based purchasing plan. The report must include:

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

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

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

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

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

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

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

The commissioner shall submit a copy of the reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by April 1 of each year. Drugs acquired through the federal 340B Drug Pricing Program and dispensed by a 340B covered entity or ambulatory pharmacy under common ownership of the 340B covered entity are not eligible for coverage if the 340B covered entity or ambulatory pharmacy under common ownership of the 340B covered entity fails to submit a report to the commissioner containing the information required under clauses (1) to (7).

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

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

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

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

Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the Formulary Committee shall review and comment on the formulary contents.

(b) The formulary shall not include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(f) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the~~

~~commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).~~

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

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

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

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

~~(i)~~ (h) The covered modes of transportation are:

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

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

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

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

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

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

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

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

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

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

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

(3) investigate all complaints and appeals.

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

~~(m)~~ (j) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph ~~(h)~~ (g), not the type of vehicle used to provide the

service. ~~The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) each entry in the record must document:

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

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

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

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

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

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

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

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

(ix) whether the service was ambulatory or nonambulatory;

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

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

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

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

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

(b) The commissioner may provide a monthly public transit pass to recipients who are well-served by public transit for the recipient's nonemergency medical transportation needs. Any recipient who is eligible for one public transit trip for a medically necessary covered service may select to receive a transit pass for that month. Recipients who do not have any transportation needs for a medically necessary service in any given month are not eligible for a transit pass that month. The commissioner shall not require recipients to select a monthly transit pass if the recipient's transportation needs cannot be served by public transit systems. Recipients who receive a monthly transit pass are not eligible for other modes of transportation, unless an unexpected need arises that cannot be accessed through public transit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) general social services and administrative costs;

(ii) retail pharmacy;

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

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

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

(ix) contributions and donations;

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

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

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

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

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

(1) can withstand repeated use;

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

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

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined

under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

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

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

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

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

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

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

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

(i) the benefits of preventative health care visits;

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

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

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

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

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

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

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

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

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

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

(1) be under the age of 21;

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

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

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

(c) Covered products include the following allergen-reducing products that are identified as needed and recommended for the child by a registered environmental health specialist, healthy homes specialist, lead risk assessor, certified asthma educator, public health nurse,

or other health care professional providing asthma care for the child, and proven to reduce asthma triggers:

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

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

(3) a dehumidifier and filters;

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

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

(6) a damp mopping system;

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

(8) for homeowners only, furnace filters.

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

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

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

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

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

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting

by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) monitor prescribing practices more frequently than annually;

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

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

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

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

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

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

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

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

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must work for a personal care assistance provider agency, meet the definition of qualified professional under section 256B.0625, subdivision 19c, ~~and enroll with the department as a qualified professional after clearing~~ clear a background study, and meet provider training requirements. Before a qualified professional provides services, the personal care assistance

provider agency must initiate a background study on the qualified professional under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional:

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

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

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

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

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

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

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

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

(c) ~~Effective July 1, 2011,~~ The qualified professional shall complete the provider training with basic information about the personal care assistance program approved by the commissioner. Newly hired qualified professionals must complete the training within six months of the date hired by a personal care assistance provider agency. Qualified professionals who have completed the required training as a worker from a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the last three years. The required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing to demonstrate an understanding of the content without attending in-person training. A qualified professional is allowed to be employed and is not subject to the training requirement until the training is offered online or through remote electronic connection. A qualified professional employed by a personal care assistance provider agency certified for

participation in Medicare as a home health agency is exempt from the training required in this subdivision. When available, the qualified professional working for a Medicare-certified home health agency must successfully complete the competency test. The commissioner shall ensure there is a mechanism in place to verify the identity of persons completing the competency testing electronically.

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

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

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians

and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, ~~Hennepin County and~~ Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed ~~$12,000,000 per year from Hennepin County and~~ $6,000,000 per year ~~from Ramsey County~~. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to ~~Hennepin County Medical Center or~~ Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to ~~Hennepin County Medical Center and~~ Regions Hospital by those plans. For the purposes of this paragraph, "the base amount" means the total annual value of increased medical assistance capitation payments, including the voluntary intergovernmental transfers, under this paragraph in calendar year 2017. For managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance capitation payments under this paragraph by an amount equal to ten percent of the base amount, and by an additional ten percent of the base amount for each subsequent contract year until December 31, 2025. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to ~~Hennepin County Medical Center and~~ Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph. This paragraph expires January 1, 2026.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul, and ambulance services owned and operated by

another governmental entity that chooses to participate by requesting the commissioner to determine an upper payment limit. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County, the city of St. Paul, and other participating governmental entities of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities. A tribal government that owns and operates an ambulance service is not eligible to participate under this subdivision.

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

(f) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (e), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

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

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

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

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

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

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

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

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

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

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

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

Subd. 4. **Voluntary intergovernmental transfers.** A nonstate governmental entity that is eligible to perform intergovernmental transfers may make voluntary intergovernmental transfers to the commissioner. The commissioner shall inform the nonstate governmental

entity of the intergovernmental transfers necessary to maximize the allowable directed payments.

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

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

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

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

Subd. 8. **State quality goals.** The directed payment arrangement and state-directed fee schedule requirement must align the state quality goals to Hennepin Healthcare medical assistance patients, including unstably housed individuals, those with higher levels of social and clinical risk, limited English proficiency (LEP) patients, adults with serious chronic conditions, and individuals of color. The directed payment arrangement must maintain quality and access to a full range of health care delivery mechanisms for these patients, that

may include behavioral health, emergent care, preventive care, hospitalization, transportation, interpreter services, and pharmaceutical services. The commissioner, in consultation with Hennepin Healthcare, shall submit to the Centers for Medicare and Medicaid Services a methodology to measure access to care and the achievement of state quality goals.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later, unless the federal approval provides for an effective date after January 1, 2022, but before the date of federal approval, in which case the federally approved effective date applies. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

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

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

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

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

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

(1) physician services - prenatal and preventive;

(2) physician services - nonprenatal and nonpreventive;

(3) dental services;

(4) inpatient hospital services;

(5) outpatient hospital services; and

(6) mental health services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) is not renewed automatically.

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

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

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

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

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

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

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

(b) (1) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed

using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics.

(2) Effective for services provided on or after July 1, 2021, the rate described in clause (1) shall be increased for hospitals providing high levels of high-cost drugs or 340B drugs. The rate adjustment shall be based on each hospital's share of the total reimbursement for 340B drugs to all critical access hospitals, but shall not exceed .... percentage points.

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

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

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

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

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

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

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

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

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

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

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

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

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

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

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

receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

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

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

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

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

~~(m)~~ (k) Effective for services provided on or after July 1, 2017, through December 31, 2022, the commissioner shall increase payment rates by 23.8 percent for dental services provided to enrollees under the age of 21. This rate increase does not apply to state-operated

dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers. This rate increase does not apply to managed care plans and county-based purchasing plans.

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

(m) Beginning January 1, 2026, and every four years thereafter, the commissioner shall rebase payment rates for dental services to the first percentile of submitted charges for the applicable base year using charge data from paid claims submitted by providers. The base year used for each rebasing shall be the calendar year that is two years prior to the effective date of the rebasing.

Sec. 48. Minnesota Statutes 2020, section 256B.76, is amended by adding a subdivision to read:

Subd. 2a. **Dental home pilot program.** The commissioner, in consultation with dental stakeholders, shall design a dental home pilot program and implement the program beginning January 1, 2023. The dental home pilot program shall provide incentives for the provision of high-quality, patient-centered, comprehensive, and coordinated oral health services by qualified providers.

Sec. 49. Minnesota Statutes 2020, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) The commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2016, through December 31, 2022, the commissioner shall increase reimbursement by 37.5 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) For dental services rendered on or after July 1, 2016, through December 31, 2022, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (d), clause (4), and is owned and operated by a health maintenance organization licensed under chapter 62D, the commissioner shall increase reimbursement

by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.

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

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

(1) nonprofit community clinics that:

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

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

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

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

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

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

(vii) have free care available as needed;

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

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

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

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

(6) private practicing dentists if:

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

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

Sec. 50. Minnesota Statutes 2020, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

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

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

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

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and

anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

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

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

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

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

(i) Effective for services provided on or after July 1, 2015, <u>through June 30, 2021,</u> the following categories of medical supplies and durable medical equipment shall be individually priced items: enteral nutrition and supplies, customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service. This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item. The commissioner shall not apply any medical assistance rate reductions

to durable medical equipment as a result of Medicare competitive bidding through June 30, 2021.

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

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

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

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

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

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

(m) Effective July 1, 2021, the payment rates for all durable medical equipment, prosthetics, orthotics, or supplies, except pressure support ventilators, shall be the lesser of

the provider's submitted charges or the Medicare fee schedule amount, with no increases or decreases described in paragraphs (a) to (k) applied. Pressure support ventilators shall be paid the Medicare rate plus 47 percent.

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

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

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

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

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

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

(4) Not more than once every three years, the alternate payment methodology rates must be evaluated by the commissioner for reasonableness by reviewing invoices from at least 20 paid claim lines and five different providers for claims paid during one calendar month or one quarter if necessary to obtain the required sample. If the evaluation identifies that the alternate payment methodology rate is more than five percent higher or lower than the provider's actual acquisition cost plus 20 percent, then the commissioner shall recalculate and update the fee schedule according to clauses (1) to (3). If the evaluation does not show that the alternate payment methodology fee schedule rate is five percent higher or lower than the provider's actual acquisition cost plus 20 percent or a sufficient sample cannot be collected due to low utilization as defined in clause (1), then the commissioner shall maintain the previously calculated alternate payment methodology rate on the fee schedule.

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

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

Sec. 51. Minnesota Statutes 2020, section 256B.767, is amended to read:

256B.767 MEDICARE PAYMENT LIMIT.

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

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

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

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

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

Sec. 52. Minnesota Statutes 2020, section 256B.79, subdivision 1, is amended to read:

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

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

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

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

Sec. 53. Minnesota Statutes 2020, section 256B.79, subdivision 3, is amended to read:

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

Sec. 54. Minnesota Statutes 2020, section 256L.01, subdivision 5, is amended to read:

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

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

Sec. 55. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

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

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

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

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

Sec. 56. Minnesota Statutes 2020, section 256L.04, subdivision 7b, is amended to read:

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

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

Sec. 57. Minnesota Statutes 2020, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Redetermination of eligibility.** (a) An enrollee's eligibility must be redetermined on an annual basis~~, in accordance with Code of Federal Regulations, title 42, section 435.916 (a). The 12-month eligibility period begins the month of application. Beginning July 1, 2017, the commissioner shall adjust the eligibility period for enrollees to implement renewals throughout the year according to guidance from the Centers for Medicare and Medicaid Services~~. The period of eligibility is the entire calendar year following the year in which eligibility is redetermined. Eligibility redeterminations shall occur during the

open enrollment period for qualified health plans as specified in Code of Federal Regulations, title 45, section 155.410(e)(3).

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

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

Sec. 58. Minnesota Statutes 2020, section 256L.11, subdivision 6a, is amended to read:

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

Sec. 59. Minnesota Statutes 2020, section 256L.11, subdivision 7, is amended to read:

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

Sec. 60. Minnesota Statutes 2020, section 295.53, subdivision 1, is amended to read:

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

(1) payments received by a health care provider or the wholly owned subsidiary of a health care provider for care provided outside Minnesota;

(2) government payments received by the commissioner of human services for state-operated services;

(3) payments received by a health care provider for hearing aids and related equipment or prescription eyewear delivered outside of Minnesota; and

(4) payments received by an educational institution from student tuition, student activity fees, health care service fees, government appropriations, donations, or grants, and for services identified in and provided under an individualized education program as defined in section 256B.0625 or Code of Federal Regulations, chapter 34, section 300.340(a). Fee for service payments and payments for extended coverage are taxable.

(b) The following payments are exempted from the gross revenues subject to hospital, surgical center, or health care provider taxes under sections 295.50 to 295.59:

(1) payments received for services provided under the Medicare program, including payments received from the government and organizations governed by sections 1833, 1853, and 1876 of title XVIII of the federal Social Security Act, United States Code, title 42, section 1395; and enrollee deductibles, co-insurance, and co-payments, whether paid by the Medicare enrollee, by Medicare supplemental coverage as described in section 62A.011, subdivision 3, clause (10), or by Medicaid payments under title XIX of the federal Social Security Act. Payments for services not covered by Medicare are taxable;

(2) payments received for home health care services;

(3) payments received from hospitals or surgical centers for goods and services on which liability for tax is imposed under section 295.52 or the source of funds for the payment is exempt under clause (1), (6), (9), (10), or (11);

(4) payments received from the health care providers for goods and services on which liability for tax is imposed under this chapter or the source of funds for the payment is exempt under clause (1), (6), (9), (10), or (11);

(5) amounts paid for legend drugs to a wholesale drug distributor who is subject to tax under section 295.52, subdivision 3, reduced by reimbursement received for legend drugs otherwise exempt under this chapter;

(6) payments received from the chemical dependency fund under chapter 254B;

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

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

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

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

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

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

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

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

Sec. 61. **COURT RULING ON AFFORDABLE CARE ACT.**

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

Sec. 62. **DELIVERY REFORM ANALYSIS REPORT.**

(a) The commissioner of human services shall present to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance, by January 15, 2023, a report comparing service delivery and payment system models for

delivering services to Medical Assistance enrollees for whom income eligibility is determined using the modified adjusted gross income methodology under Minnesota Statutes, section 256B.056, subdivision 1a, paragraph (b), clause (1), and MinnesotaCare enrollees eligible under Minnesota Statutes, chapter 256L. The report must compare the current delivery model with at least two alternative models. The alternative models must include a state-based model, in which the state holds the plan risk as the insurer and may contract with a third-party administrator for claims processing and plan administration. The alternative models may include, but are not limited to:

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

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

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

(b) The report must include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The commissioner of human services, in consultation with the commissioners of commerce and health, shall assess the feasibility of, and develop recommendations for: (1) expanding the outpatient prescription drug carve out under Minnesota Statutes, section 256B.69, subdivision 6d, to include MinnesotaCare enrollees; and (2) establishing a prescription drug purchasing program to serve nonpublic program enrollees of health plan companies. The recommendations must address the process and terms by which the

commissioner would contract with health plan companies to administer prescription drug benefits for their enrollees and develop and manage a formulary. The commissioner shall present recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services policy and finance by December 15, 2023.

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

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

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

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

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

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

(2) allow undocumented non-citizens, and individuals with access to subsidized employer health coverage who are subject to the family glitch, to purchase the public option;

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

(4) allow the state to:

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

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

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

(b) Each public option proposal must include:

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

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

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

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

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

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

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

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

(b) Notwithstanding any provision to the contrary, periodic data matching under Minnesota Statutes, section 256B.0561, subdivision 2, may be suspended for up to six

months following the last day of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

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

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

Sec. 68. **REVISOR INSTRUCTION.**

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

Sec. 69. **REPEALER.**

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

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

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

ARTICLE 2
DHS LICENSING AND BACKGROUND STUDIES

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

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

(1) each navigator;

(2) each in-person assister; and

(3) each certified application counselor.

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

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

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

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

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

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

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

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

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

(b) The background ~~check~~ study for all first-time teaching applicants for licenses must include a review of information from the Bureau of Criminal Apprehension, including criminal history data as defined in section 13.87, and must also include a review of the national criminal records repository. The superintendent of the Bureau of Criminal Apprehension is authorized to exchange fingerprints with the Federal Bureau of Investigation

for purposes of the criminal history check. ~~The superintendent shall recover the cost to the bureau of a background check through the fee charged to the applicant under paragraph (a).~~

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

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

245A.05 DENIAL OF APPLICATION.

(a) The commissioner may deny a license if an applicant or controlling individual:

(1) fails to submit a substantially complete application after receiving notice from the commissioner under section 245A.04, subdivision 1;

(2) fails to comply with applicable laws or rules;

(3) knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation;

(4) has a disqualification that has not been set aside under section 245C.22 and no variance has been granted;

(5) has an individual living in the household who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (2), who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted;

(6) is associated with an individual who received a background study under section 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to children or vulnerable adults, and who has a disqualification that has not been set aside under section 245C.22, and no variance has been granted;

(7) fails to comply with section 245A.04, subdivision 1, paragraph (f) or (g);

(8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision 6;

(9) has a history of noncompliance as a license holder or controlling individual with applicable laws or rules, including but not limited to this chapter and chapters 119B and 245C; ~~or~~

(10) is prohibited from holding a license according to section 245.095~~.~~; or

(11) for a family foster setting, has nondisqualifying background study information, as described in section 245C.05, subdivision 4, that reflects on the individual's ability to safely provide care to foster children.

(b) An applicant whose application has been denied by the commissioner must be given notice of the denial, which must state the reasons for the denial in plain language. Notice must be given by certified mail or personal service. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an appeal request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the notice of denial. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

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

Sec. 4. Minnesota Statutes 2020, section 245A.07, subdivision 1, is amended to read:

Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional under section 245A.06, the commissioner may suspend or revoke the license, impose a fine, or secure an injunction against the continuing operation of the program of a license holder who does not comply with applicable law or rule, or who has nondisqualifying background study information, as described in section 245C.05, subdivision 4, that reflects on the license holder's ability to safely provide care to foster children. When applying sanctions authorized under this section, the commissioner shall consider the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

(b) If a license holder appeals the suspension or revocation of a license and the license holder continues to operate the program pending a final order on the appeal, the commissioner shall issue the license holder a temporary provisional license. Unless otherwise specified by the commissioner, variances in effect on the date of the license sanction under appeal continue under the temporary provisional license. If a license holder fails to comply with applicable law or rule while operating under a temporary provisional license, the commissioner may impose additional sanctions under this section and section 245A.06, and may terminate any prior variance. If a temporary provisional license is set to expire, a new temporary provisional license shall be issued to the license holder upon payment of any fee

required under section 245A.10. The temporary provisional license shall expire on the date the final order is issued. If the license holder prevails on the appeal, a new nonprovisional license shall be issued for the remainder of the current license period.

(c) If a license holder is under investigation and the license issued under this chapter is due to expire before completion of the investigation, the program shall be issued a new license upon completion of the reapplication requirements and payment of any applicable license fee. Upon completion of the investigation, a licensing sanction may be imposed against the new license under this section, section 245A.06, or 245A.08.

(d) Failure to reapply or closure of a license issued under this chapter by the license holder prior to the completion of any investigation shall not preclude the commissioner from issuing a licensing sanction under this section or section 245A.06 at the conclusion of the investigation.

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

Sec. 5. Minnesota Statutes 2020, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600
125 to 149 persons	$700
150 to 174 persons	$800
175 to 199 persons	$900
200 to 224 persons	$1,000
225 or more persons	$1,100

(b)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee based on revenues derived from the provision of services that would require licensure under chapter 245D during the calendar year immediately preceding the year in which the license fee is paid, according to the following schedule:

License Holder Annual Revenue	License Fee
less than or equal to $10,000	$200
greater than $10,000 but less than or equal to $25,000	$300
greater than $25,000 but less than or equal to $50,000	$400
greater than $50,000 but less than or equal to $100,000	$500
greater than $100,000 but less than or equal to $150,000	$600
greater than $150,000 but less than or equal to $200,000	$800
greater than $200,000 but less than or equal to $250,000	$1,000
greater than $250,000 but less than or equal to $300,000	$1,200
greater than $300,000 but less than or equal to $350,000	$1,400
greater than $350,000 but less than or equal to $400,000	$1,600
greater than $400,000 but less than or equal to $450,000	$1,800
greater than $450,000 but less than or equal to $500,000	$2,000
greater than $500,000 but less than or equal to $600,000	$2,250
greater than $600,000 but less than or equal to $700,000	$2,500
greater than $700,000 but less than or equal to $800,000	$2,750
greater than $800,000 but less than or equal to $900,000	$3,000
greater than $900,000 but less than or equal to $1,000,000	$3,250
greater than $1,000,000 but less than or equal to $1,250,000	$3,500
greater than $1,250,000 but less than or equal to $1,500,000	$3,750
greater than $1,500,000 but less than or equal to $1,750,000	$4,000
greater than $1,750,000 but less than or equal to $2,000,000	$4,250
greater than $2,000,000 but less than or equal to $2,500,000	$4,500

greater than $2,500,000 but less than or equal to $3,000,000	$4,750
greater than $3,000,000 but less than or equal to $3,500,000	$5,000
greater than $3,500,000 but less than or equal to $4,000,000	$5,500
greater than $4,000,000 but less than or equal to $4,500,000	$6,000
greater than $4,500,000 but less than or equal to $5,000,000	$6,500
greater than $5,000,000 but less than or equal to $7,500,000	$7,000
greater than $7,500,000 but less than or equal to $10,000,000	$8,500
greater than $10,000,000 but less than or equal to $12,500,000	$10,000
greater than $12,500,000 but less than or equal to $15,000,000	$14,000
greater than $15,000,000	$18,000

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(5) Notwithstanding clause (1), a license holder providing services under one or more licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license holder for all licenses held under chapter 245B for calendar year 2013. For calendar year 2017 and thereafter, the license holder shall pay an annual license fee according to clause (1).

(c) A chemical dependency treatment program licensed under chapter 245G, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600

25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

(d) A ~~chemical dependency~~ detoxification program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, ~~to provide detoxification services~~ or a withdrawal management program licensed under chapter 245F shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

A detoxification program that also operates a withdrawal management program at the same location shall only pay one fee based upon the licensed capacity of the program with the higher overall capacity.

(e) Except for child foster care, a residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

(f) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

(g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(h) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of $1,500.

(i) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

(j) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900
75 to 99 persons	$1,100
100 or more persons	$1,300

(k) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(l) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of $1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

Sec. 6. Minnesota Statutes 2020, section 245A.16, is amended by adding a subdivision to read:

Subd. 9. **Licensed family foster settings.** (a) Before recommending to grant a license, deny a license under section 245A.05, or revoke a license under section 245A.07 for nondisqualifying background study information received under section 245C.05, subdivision

4, paragraph (a), clause (3), for a licensed family foster setting, a county agency or private agency that has been designated or licensed by the commissioner must review the following:

(1) the type of offenses;

(2) the number of offenses;

(3) the nature of the offenses;

(4) the age of the individual at the time of the offenses;

(5) the length of time that has elapsed since the last offense;

(6) the relationship of the offenses and the capacity to care for a child;

(7) evidence of rehabilitation;

(8) information or knowledge from community members regarding the individual's capacity to provide foster care;

(9) any available information regarding child maltreatment reports or child in need of protection or services petitions, or related cases, in which the individual has been involved or implicated, and documentation that the individual has remedied issues or conditions identified in child protection or court records that are relevant to safely caring for a child;

(10) a statement from the study subject;

(11) a statement from the license holder; and

(12) other aggravating and mitigating factors.

(b) For purposes of this section, "evidence of rehabilitation" includes but is not limited to the following:

(1) maintaining a safe and stable residence;

(2) continuous, regular, or stable employment;

(3) successful participation in an education or job training program;

(4) positive involvement with the community or extended family;

(5) compliance with the terms and conditions of probation or parole following the individual's most recent conviction;

(6) if the individual has had a substance use disorder, successful completion of a substance use disorder assessment, substance use disorder treatment, and recommended continuing care, if applicable, demonstrated abstinence from controlled substances, as defined in section 152.01, subdivision 4, or the establishment of a sober network;

(7) if the individual has had a mental illness or documented mental health issues, demonstrated completion of a mental health evaluation, participation in therapy or other recommended mental health treatment, or appropriate medication management, if applicable;

(8) if the individual's offense or conduct involved domestic violence, demonstrated completion of a domestic violence or anger management program, and the absence of any orders for protection or harassment restraining orders against the individual since the previous offense or conduct;

(9) written letters of support from individuals of good repute, including but not limited to employers, members of the clergy, probation or parole officers, volunteer supervisors, or social services workers;

(10) demonstrated remorse for convictions or conduct, or demonstrated positive behavior changes; and

(11) absence of convictions or arrests since the previous offense or conduct, including any convictions that were expunged or pardoned.

(c) An applicant for a family foster setting license must sign all releases of information requested by the county or private licensing agency.

(d) When licensing a relative for a family foster setting, the commissioner shall also consider the importance of maintaining the child's relationship with relatives as an additional significant factor in determining whether an application will be denied.

(e) When recommending that the commissioner deny or revoke a license, the county or private licensing agency must send a summary of the review completed according to paragraph (a), on a form developed by the commissioner, to the commissioner and include any recommendation for licensing action.

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

Sec. 7. Minnesota Statutes 2020, section 245C.02, subdivision 4a, is amended to read:

Subd. 4a. **Authorized fingerprint collection vendor.** "Authorized fingerprint collection vendor" means a qualified organization under a written contract with the commissioner to provide services in accordance with section 245C.05, subdivision 5, paragraph (b). The commissioner may retain the services of more than one authorized fingerprint collection vendor.

Sec. 8. Minnesota Statutes 2020, section 245C.02, subdivision 5, is amended to read:

Subd. 5. **Background study.** "Background study" means:

(1) the collection and processing of a background study subject's fingerprints, including the process of obtaining a background study subject's classifiable fingerprints and photograph as required by section 245C.05, subdivision 5, paragraph (b); and

(2) the review of records conducted by the commissioner to determine whether a subject is disqualified from direct contact with persons served by a program and, where specifically provided in statutes, whether a subject is disqualified from having access to persons served by a program and from working in a children's residential facility or foster residence setting.

Sec. 9. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision to read:

Subd. 5b. **Alternative background study.** "Alternative background study" means:

(1) the collection and processing of a background study subject's fingerprints, including the process of obtaining a background study subject's classifiable fingerprints and photograph as required by section 245C.05, subdivision 5, paragraph (b); and

(2) a review of records conducted by the commissioner pursuant to section 245C.08 in order to forward the background study investigating information to the entity that submitted the alternative background study request under section 245C.031, subdivision 2. The commissioner shall not make any eligibility determinations on background studies conducted under section 245C.031.

Sec. 10. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision to read:

Subd. 11c. **Entity.** "Entity" means any program, organization, or agency initiating a background study.

Sec. 11. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision to read:

Subd. 16a. **Results.** "Results" means a determination that a study subject is eligible, disqualified, set aside, granted a variance, or that more time is needed to complete the background study.

Sec. 12. Minnesota Statutes 2020, section 245C.03, is amended to read:

245C.03 BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study on:

(1) the person or persons applying for a license;

(2) an individual age 13 and over living in the household where the licensed program will be provided who is not receiving licensed services from the program;

(3) current or prospective employees or contractors of the applicant who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program, when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(7) all controlling individuals as defined in section 245A.02, subdivision 5a;

(8) notwithstanding the other requirements in this subdivision, child care background study subjects as defined in section 245C.02, subdivision 6a; and

(9) notwithstanding clause (3), for children's residential facilities and foster residence settings, any adult working in the facility, whether or not the individual will have direct contact with persons served by the facility.

(b) For child foster care when the license holder resides in the home where foster care services are provided, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

(c) This subdivision applies to the following programs that must be licensed under chapter 245A:

(1) adult foster care;

(2) child foster care;

(3) children's residential facilities;

(4) family child care;

(5) licensed child care centers;

(6) licensed home and community-based services under chapter 245D;

(7) residential mental health programs for adults;

(8) substance use disorder treatment programs under chapter 245G;

(9) withdrawal management programs under chapter 245F;

(10) programs that provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons;

(11) adult day care centers;

(12) family adult day services;

(13) independent living assistance for youth;

(14) detoxification programs;

(15) community residential settings; and

(16) intensive residential treatment services and residential crisis stabilization under chapter 245I.

Subd. 1a. **Procedure.** (a) Individuals and organizations that are required under this section to have or initiate background studies shall comply with the requirements of this chapter.

(b) All studies conducted under this section shall be conducted according to sections 299C.60 to 299C.64. This requirement does not apply to subdivisions 1, paragraph (c), clauses (2) to (5), and 6a.

Subd. 2. **Personal care provider organizations.** The commissioner shall conduct background studies on any individual required under sections 256B.0651 to 256B.0654 and 256B.0659 to have a background study completed under this chapter.

Subd. 3. **Supplemental nursing services agencies.** The commissioner shall conduct all background studies required under this chapter and initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1.

Subd. 3a. **Personal care assistance provider agency; background studies.** Personal care assistance provider agencies enrolled to provide personal care assistance services under the medical assistance program must meet the following requirements:

(1) owners who have a five percent interest or more and all managing employees are subject to a background study as provided in this chapter. This requirement applies to currently enrolled personal care assistance provider agencies and agencies seeking enrollment as a personal care assistance provider agency. "Managing employee" has the same meaning as Code of Federal Regulations, title 42, section 455. An organization is barred from enrollment if:

(i) the organization has not initiated background studies of owners and managing employees; or

(ii) the organization has initiated background studies of owners and managing employees and the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified under section 245C.14, and the owner or managing employee has not received a set aside of the disqualification under section 245C.22; and

(2) a background study must be initiated and completed for all qualified professionals.

Subd. 3b. **Exception to personal care assistant; requirements.** The personal care assistant for a recipient may be allowed to enroll with a different personal care assistance provider agency upon initiation of a new background study according to this chapter if:

(1) the commissioner determines that a change in enrollment or affiliation of the personal care assistant is needed in order to ensure continuity of services and protect the health and safety of the recipient;

(2) the chosen agency has been continuously enrolled as a personal care assistance provider agency for at least two years;

(3) the recipient chooses to transfer to the personal care assistance provider agency;

(4) the personal care assistant has been continuously enrolled with the former personal care assistance provider agency since the last background study was completed; and

(5) the personal care assistant continues to meet requirements of section 256B.0659, subdivision 11, notwithstanding paragraph (a), clause (3).

Subd. 4. **Personnel agencies; educational programs; professional services agencies.** The commissioner also may conduct studies on individuals specified in subdivision 1, paragraph (a), clauses (3) and (4), when the studies are initiated by:

(1) personnel pool agencies;

(2) temporary personnel agencies;

(3) educational programs that train individuals by providing direct contact services in licensed programs; and

(4) professional services agencies that are not licensed and which contract with licensed programs to provide direct contact services or individuals who provide direct contact services.

Subd. 5. **Other state agencies.** The commissioner shall conduct background studies on applicants and license holders under the jurisdiction of other state agencies who are required in other statutory sections to initiate background studies under this chapter, including the applicant's or license holder's employees, contractors, and volunteers when required under other statutory sections.

Subd. 5a. **Facilities serving children or adults licensed or regulated by the Department of Health.** (a) The commissioner shall conduct background studies of:

(1) individuals providing services who have direct contact, as defined under section 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; assisted living facilities and assisted living facilities with dementia care licensed under chapter 144G; and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17;

(2) individuals specified in subdivision 2 who provide direct contact services in a nursing home or a home care agency licensed under chapter 144A; an assisted living facility or assisted living facility with dementia care licensed under chapter 144G; or a boarding care home licensed under sections 144.50 to 144.58. If the individual undergoing a study resides outside of Minnesota, the study must include a check for substantiated findings of maltreatment of adults and children in the individual's state of residence when the state makes the information available;

(3) all other employees in assisted living facilities or assisted living facilities with dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact with or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as

defined in section 245C.02, subdivision 8, when the employee's employment responsibilities do not include providing direct contact services;

(4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

(5) controlling persons of a supplemental nursing services agency, as defined by section 144A.70.

(b) If a facility or program is licensed by the Department of Human Services and the Department of Health and is subject to the background study provisions of this chapter, the Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed program.

Subd. 5b. **Facilities serving children or youth licensed by the Department of Corrections.** (a) The commissioner shall conduct background studies of individuals providing services in secure and nonsecure residential facilities, juvenile detention facilities, and foster residence settings, who have direct contact, as defined under section 245C.02, subdivision 11, with persons served in the facilities or settings.

(b) A clerk or administrator of any court, the Bureau of Criminal Apprehension, a prosecuting attorney, a county sheriff, or a chief of a local police department shall assist in conducting background studies by providing the commissioner of human services or the commissioner's representative with all criminal conviction data available from local and state criminal history record repositories, related to applicants, operators, all persons living in a household, and all staff of any facility subject to background studies under this subdivision.

(c) For the purpose of this subdivision, the term "secure and nonsecure residential facility and detention facility" includes programs licensed or certified under section 241.021, subdivision 2.

(d) If an individual is disqualified, the Department of Human Services shall notify the disqualified individual and the facility in which the disqualified individual provides services and shall inform the disqualified individual of the right to request a reconsideration of the disqualification by submitting the request to the Department of Corrections.

(e) The commissioner of corrections shall review and make decisions regarding reconsideration requests, including whether to grant variances, according to the procedures and criteria in this chapter. The commissioner of corrections shall inform the requesting individual and the Department of Human Services of the commissioner's decision. The

commissioner's decision to grant or deny a reconsideration of a disqualification is the final administrative agency action.

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** The commissioner shall conduct background studies ~~on~~ of any individual ~~required under section 256B.4912 to have a background study completed under this chapter~~ who provides direct contact, as defined in section 245C.02, subdivision 11, for services specified in the federally approved home and community-based waiver plans under section 256B.4712 and the individual studied must meet the requirements of this chapter prior to providing waiver services and as part of ongoing enrollment. Upon federal approval, this requirement applies to consumer-directed community supports.

Subd. 6a. **Legal nonlicensed and certified child care programs.** The commissioner shall conduct background studies ~~on an individual~~ of the following individuals as required ~~under~~ by sections 119B.125 and 245H.10 ~~to complete a background study under this chapter.~~:

(1) every individual who applies for certification;

(2) every member of a provider's household who is age 13 and older and lives in the household where nonlicensed child care is provided; and

(3) an individual who is at least ten years of age and under 13 years of age and lives in the household where the nonlicensed child care will be provided when the county has reasonable cause as defined under section 245C.02, subdivision 15.

Subd. 7. **Children's therapeutic services and supports providers.** The commissioner shall conduct background studies ~~according to this chapter when initiated by a children's therapeutic services and supports provider~~ of all direct service providers and volunteers for children's therapeutic services and supports providers under section 256B.0943.

~~Subd. 8. **Self-initiated background studies.** Upon implementation of NETStudy 2.0, the commissioner shall conduct background studies according to this chapter when initiated by an individual who is not on the master roster. A subject under this subdivision who is not disqualified must be placed on the inactive roster.~~

Subd. 9. **Community first services and supports organizations.** ~~The commissioner shall conduct background studies on any individual required under section 256B.85 to have a background study completed under this chapter.~~ Individuals affiliated with Community First Services and Supports (CFSS) agency-providers and Financial Management Services (FMS) providers enrolled to provide CFSS services under the medical assistance program must meet the following requirements:

(1) owners who have a five percent interest or more and all managing employees are subject to a background study under this chapter. This requirement applies to currently enrolled providers and agencies seeking enrollment. "Managing employee" has the meaning given in Code of Federal Regulations, title 42, section 455.101. An organization is barred from enrollment if:

(i) the organization has not initiated background studies of owners and managing employees; or

(ii) the organization has initiated background studies of owners and managing employees and the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified under section 245C.14 and the owner or managing employee has not received a set aside of the disqualification under section 245C.22;

(2) a background study must be initiated and completed for all staff who will have direct contact with the participant to provide worker training and development; and

(3) a background study must be initiated and completed for all support workers.

Subd. 9a. **Exception to support worker requirements for continuity of services.** The support worker for a participant may enroll with a different Community First Services and Supports (CFSS) agency-provider or Financial Management Services (FMS) provider upon initiation, rather than completion, of a new background study according to this chapter if:

(1) the commissioner determines that the support worker's change in enrollment or affiliation is necessary to ensure continuity of services and to protect the health and safety of the participant;

(2) the chosen agency-provider or FMS provider has been continuously enrolled as a CFSS agency-provider or FMS provider for at least two years or since the inception of the CFSS program, whichever is shorter;

(3) the participant served by the support worker chooses to transfer to the CFSS agency-provider or the FMS provider to which the support worker is transferring;

(4) the support worker has been continuously enrolled with the former CFSS agency-provider or FMS provider since the support worker's last background study was completed; and

(5) the support worker continues to meet the requirements of section 256B.85, subdivision 16, notwithstanding paragraph (a), clause (1).

Subd. 10. **Providers of group residential housing or supplementary services.** (a) The commissioner shall conduct background studies ~~on any individual required under section 256I.04 to have a background study completed under this chapter.~~ of the following individuals who provide services under section 256I.04:

(1) controlling individuals as defined in section 245A.02;

(2) managerial officials as defined in section 245A.02; and

(3) all employees and volunteers of the establishment who have direct contact with recipients or who have unsupervised access to recipients, recipients' personal property, or recipients' private data.

(b) The provider of housing support must comply with all requirements for entities initiating background studies under this chapter.

(c) A provider of housing support must demonstrate that all individuals who are required to have a background study according to paragraph (a) have a notice stating that:

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

(2) the individual is disqualified and the individual has been issued a set aside of the disqualification for the setting under section 245C.22.

~~Subd. 11. **Child protection workers or social services staff having responsibility for child protective duties.** (a) The commissioner must complete background studies, according to paragraph (b) and section 245C.04, subdivision 10, when initiated by a county social services agency or by a local welfare agency according to section 626.559, subdivision 1b.~~

~~(b) For background studies completed by the commissioner under this subdivision, the commissioner shall not make a disqualification decision, but shall provide the background study information received to the county that initiated the study.~~

Subd. 12. **Providers of special transportation service.** (a) The commissioner shall conduct background studies ~~on any individual required under section 174.30 to have a background study completed under this chapter.~~ of the following individuals who provide special transportation services under section 174.30:

(1) each person with a direct or indirect ownership interest of five percent or higher in a transportation service provider;

(2) each controlling individual as defined under section 245A.02;

(3) a managerial official as defined in section 245A.02;

(4) each driver employed by the transportation service provider;

(5) each individual employed by the transportation service provider to assist a passenger during transport; and

(6) each employee of the transportation service agency who provides administrative support, including an employee who:

(i) may have face-to-face contact with or access to passengers, passengers' personal property, or passengers' private data;

(ii) performs any scheduling or dispatching tasks; or

(iii) performs any billing activities.

(b) When a local or contracted agency is authorizing a ride under section 256B.0625, subdivision 17, by a volunteer driver, and the agency authorizing the ride has a reason to believe that the volunteer driver has a history that would disqualify the volunteer driver or that may pose a risk to the health or safety of passengers, the agency may initiate a background study that shall be completed according to this chapter using the commissioner of human services' online NETStudy system, or by contacting the Department of Human Services background study division for assistance. The agency that initiates the background study under this paragraph shall be responsible for providing the volunteer driver with the privacy notice required by section 245C.05, subdivision 2c, and with the payment for the background study required by section 245C.10 before the background study is completed.

Subd. 13. **Providers of housing support services.** The commissioner shall conduct background studies ~~on~~ of any ~~individual~~ provider of housing support services required ~~under~~ by section 256B.051 to have a background study completed under this chapter.

Subd. 14. **Tribal nursing facilities.** For completed background studies to comply with a tribal organization's licensing requirements for individuals affiliated with a tribally licensed nursing facility, the commissioner shall obtain state and national criminal history data.

Subd. 15. **Early intensive developmental and behavioral intervention providers.** The commissioner shall conduct background studies according to this chapter when initiated by an early intensive developmental and behavioral intervention provider under section 256B.0949.

EFFECTIVE DATE. This section is effective July 1, 2021, except subdivision 15 is effective the day following final enactment.

Sec. 13. **[245C.031] BACKGROUND STUDY; ALTERNATIVE BACKGROUND STUDIES.**

Subdivision 1. **Alternative background studies.** (a) The commissioner shall conduct an alternative background study of individuals listed in this section.

(b) Notwithstanding other sections of this chapter, all alternative background studies except subdivision 12 shall be conducted according to this section and with section 299C.60 to 299C.64.

(c) All terms in this section shall have the definitions provided in section 245C.02.

(d) The entity that submits an alternative background study request under this section shall submit the request to the commissioner according to section 245C.05.

(e) The commissioner shall comply with the destruction requirements in section 245C.051.

(f) Background studies conducted under this section are subject to the provisions of section 245C.32.

(g) The commissioner shall forward all information that the commissioner receives under section 245C.08 to the entity that submitted the alternative background study request under subdivision 2. The commissioner shall not make any eligibility determinations regarding background studies conducted under this section.

Subd. 2. **Access to information.** Each entity that submits an alternative background study request shall enter into an agreement with the commissioner before submitting requests for alternative background studies under this section. As a part of the agreement, the entity must agree to comply with state and federal law.

Subd. 3. **Child protection workers or social services staff having responsibility for child protective duties.** The commissioner shall conduct an alternative background study of any person who has responsibility for child protection duties when the background study is initiated by a county social services agency or by a local welfare agency according to section 260E.36, subdivision 3.

Subd. 4. **Applicants, licensees, and other occupations regulated by the commissioner of health.** The commissioner shall conduct an alternative background study, including a check of state data, and a national criminal history records check of the following individuals. For studies under this section, the following persons shall complete a consent form:

(1) an applicant for initial licensure, temporary licensure, or relicensure after a lapse in licensure as an audiologist or speech-language pathologist or an applicant for initial

certification as a hearing instrument dispenser who must submit to a background study under section 144.0572.

(2) an applicant for a renewal license or certificate as an audiologist, speech-language pathologist, or hearing instrument dispenser who was licensed or obtained a certificate before January 1, 2018.

Subd. 5. **Guardians and conservators.** (a) The commissioner shall conduct an alternative background study of:

(1) every court-appointed guardian and conservator, unless a background study has been completed of the person under this section within the previous five years. The alternative background study shall be completed prior to the appointment of the guardian or conservator, unless a court determines that it would be in the best interests of the ward or protected person to appoint a guardian or conservator before the alternative background study can be completed. If the court appoints the guardian or conservator while the alternative background study is pending, the alternative background study must be completed as soon as reasonably possible after the guardian or conservator's appointment and no later than 30 days after the guardian or conservator's appointment; and

(2) a guardian and a conservator once every five years after the guardian or conservator's appointment if the person continues to serve as a guardian or conservator.

(b) An alternative background study is not required if the guardian or conservator is:

(1) a state agency or county;

(2) a parent or guardian of a proposed ward or protected person who has a developmental disability if the parent or guardian has raised the proposed ward or protected person in the family home until the time that the petition is filed, unless counsel appointed for the proposed ward or protected person under section 524.5-205, paragraph (d); 524.5-304, paragraph (b); 524.5-405, paragraph (a); or 524.5-406, paragraph (b), recommends a background study; or

(3) a bank with trust powers, a bank and trust company, or a trust company, organized under the laws of any state or of the United States and regulated by the commissioner of commerce or a federal regulator.

Subd. 6. **Guardians and conservators; required checks.** (a) An alternative background study for a guardian or conservator pursuant to subdivision 5 shall include:

(1) criminal history data from the Bureau of Criminal Apprehension and other criminal history data obtained by the commissioner of human services;

(2) data regarding whether the person has been a perpetrator of substantiated maltreatment of a vulnerable adult under section 626.557 or a minor under chapter 260E. If the subject of the study has been the perpetrator of substantiated maltreatment of a vulnerable adult or a minor, the commissioner must include a copy of the public portion of the investigation memorandum under section 626.557, subdivision 12b, or the public portion of the investigation memorandum under section 260E.30. The commissioner shall provide the court with information from a review of information according to subdivision 7 if the study subject provided information that the study subject has a current or prior affiliation with a state licensing agency;

(3) criminal history data from a national criminal history record check as defined in section 245C.02, subdivision 13c; and

(4) state licensing agency data if a search of the database or databases of the agencies listed in subdivision 7 shows that the proposed guardian or conservator has held a professional license directly related to the responsibilities of a professional fiduciary from an agency listed in subdivision 7 that was conditioned, suspended, revoked, or canceled.

(b) If the guardian or conservator is not an individual, the background study must be completed of all individuals who are currently employed by the proposed guardian or conservator who are responsible for exercising powers and duties under the guardianship or conservatorship.

Subd. 7. **Guardians and conservators; state licensing data.** (a) Within 25 working days of receiving the request, the commissioner shall provide the court with licensing agency data for licenses directly related to the responsibilities of a guardian or conservator if the study subject has a current or prior affiliation with the:

(1) Lawyers Responsibility Board;

(2) State Board of Accountancy;

(3) Board of Social Work;

(4) Board of Psychology;

(5) Board or Nursing;

(6) Board of Medical Practice;

(7) Department of Education;

(8) Department of Commerce;

(9) Board of Chiropractic Examiners;

(10) Board of Dentistry;

(11) Board of Marriage and Family Therapy;

(12) Department of Human Services;

(13) Peace Officer Standards and Training (POST) Board; and

(14) Professional Educator Licensing and Standards Board.

(b) The commissioner and each of the agencies listed above, except for the Department of Human Services, shall enter into a written agreement to provide the commissioner with electronic access to the relevant licensing data and to provide the commissioner with a quarterly list of new sanctions issued by the agency.

(c) The commissioner shall provide to the court the electronically available data maintained in the agency's database, including whether the proposed guardian or conservator is or has been licensed by the agency, and whether a disciplinary action or a sanction against the individual's license, including a condition, suspension, revocation, or cancellation is in the licensing agency's database.

(d) If the proposed guardian or conservator has resided in a state other than Minnesota during the previous ten years, licensing agency data under this section shall also include licensing agency data from any other state where the proposed guardian or conservator reported to have resided during the previous ten years if the study subject has a current or prior affiliation to the licensing agency. If the proposed guardian or conservator has or has had a professional license in another state that is directly related to the responsibilities of a guardian or conservator from one of the agencies listed under paragraph (a), state licensing agency data shall also include data from the relevant licensing agency of the other state.

(e) The commissioner is not required to repeat a search for Minnesota or out-of-state licensing data on an individual if the commissioner has provided this information to the court within the prior five years.

(f) The commissioner shall review the information in paragraph (c) at least once every four months to determine whether an individual who has been studied within the previous five years:

(1) has any new disciplinary action or sanction against the individual's license; or

(2) did not disclose a prior or current affiliation with a Minnesota licensing agency.

(g) If the commissioner's review in paragraph (f) identifies new information, the commissioner shall provide any new information to the court.

Subd. 8. **Guardians ad litem.** The commissioner shall conduct an alternative background study of:

(1) a guardian ad litem appointed under section 518.165 if a background study of the guardian ad litem has not been completed within the past three years. The background study of the guardian ad litem must be completed before the court appoints the guardian ad litem, unless the court determines that it is in the best interests of the child to appoint the guardian ad litem before a background study is completed by the commissioner.

(2) a guardian ad litem once every three years after the guardian has been appointed, as long as the individual continues to serve as a guardian ad litem.

Subd. 9. **Guardians ad litem; required checks.** (a) An alternative background study for a guardian ad litem under subdivision 8 must include:

(1) criminal history data from the Bureau of Criminal Apprehension and other criminal history data obtained by the commissioner of human services; and

(2) data regarding whether the person has been a perpetrator of substantiated maltreatment of a minor or a vulnerable adult. If the study subject has been determined by the Department of Human Services or the Department of Health to be the perpetrator of substantiated maltreatment of a minor or a vulnerable adult in a licensed facility, the response must include a copy of the public portion of the investigation memorandum under section 260E.30 or the public portion of the investigation memorandum under section 626.557, subdivision 12b. When the background study shows that the subject has been determined by a county adult protection or child protection agency to have been responsible for maltreatment, the court shall be informed of the county, the date of the finding, and the nature of the maltreatment that was substantiated.

(b) For checks of records under paragraph (a), clauses (1) and (2), the commissioner shall provide the records within 15 working days of receiving the request. The information obtained under sections 245C.05 and 245C.08 from a national criminal history records check shall be provided within three working days of the commissioner's receipt of the data.

(c) Notwithstanding section 260E.30 or 626.557, subdivision 12b, if the commissioner or county lead agency or lead investigative agency has information that a person of whom a background study was previously completed under this section has been determined to be a perpetrator of maltreatment of a minor or vulnerable adult, the commissioner or the county may provide this information to the court that requested the background study.

Subd. 10. **First-time applicants for educator licenses with the Professional Educator Licensing and Standards Board.** The Professional Educator Licensing and Standards Board shall make all eligibility determinations for alternative background studies conducted under this section for the Professional Educator Licensing and Standards Board. The commissioner may conduct an alternative background study of all first-time applicants for educator licenses pursuant to section 122A.18, subdivision 8. The alternative background study for all first-time applicants for educator licenses must include a review of information from the Bureau of Criminal Apprehension, including criminal history data as defined in section 13.87, and must also include a review of the national criminal records repository.

Subd. 11. **First-time applicants for administrator licenses with the Board of School Administrators.** The Board of School Administrators shall make all eligibility determinations for alternative background studies conducted under this section for the Board of School Administrators. The commissioner may conduct an alternative background study of all first-time applicants for administrator licenses pursuant to section 122A.18, subdivision 8. The alternative background study for all first-time applicants for administrator licenses must include a review of information from the Bureau of Criminal Apprehension, including criminal history data as defined in section 13.87, and must also include a review of the national criminal records repository.

Subd. 12. **Occupations regulated by MNsure.** (a) The commissioner shall conduct a background study of any individual required under section 62V.05 to have a background study completed under this chapter. Notwithstanding subdivision 1, paragraph (g), the commissioner shall conduct a background study only based on Minnesota criminal records of:

(1) each navigator;

(2) each in-person assister; and

(3) each certified application counselor.

(b) The MNsure board of directors may initiate background studies required by paragraph (a) using the online NETStudy 2.0 system operated by the commissioner.

(c) The commissioner shall review information that the commissioner receives to determine if the study subject has potentially disqualifying offenses. The commissioner shall send a letter to the subject indicating any of the subject's potential disqualifications as well as any relevant records. The commissioner shall send a copy of the letter indicating any of the subject's potential disqualifications to the MNsure board.

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

Sec. 14. Minnesota Statutes 2020, section 245C.05, subdivision 1, is amended to read:

Subdivision 1. **Individual studied.** (a) The individual who is the subject of the background study must provide the applicant, license holder, or other entity under section 245C.04 with sufficient information to ensure an accurate study, including:

(1) the individual's first, middle, and last name and all other names by which the individual has been known;

(2) current home address, city, and state of residence;

(3) current zip code;

(4) sex;

(5) date of birth;

(6) driver's license number or state identification number; and

(7) upon implementation of NETStudy 2.0, the home address, city, county, and state of residence for the past five years.

(b) Every subject of a background study conducted or initiated by counties or private agencies under this chapter must also provide the home address, city, county, and state of residence for the past five years.

(c) Every subject of a background study related to private agency adoptions or related to child foster care licensed through a private agency, who is 18 years of age or older, shall also provide the commissioner a signed consent for the release of any information received from national crime information databases to the private agency that initiated the background study.

(d) The subject of a background study shall provide fingerprints and a photograph as required in subdivision 5.

(e) The subject of a background study shall submit a completed criminal and maltreatment history records check consent form for applicable national and state level record checks.

Sec. 15. Minnesota Statutes 2020, section 245C.05, subdivision 2, is amended to read:

Subd. 2. **Applicant, license holder, or other entity.** (a) The applicant, license holder, or other ~~entities~~ entity initiating the background study as provided in this chapter shall verify that the information collected under subdivision 1 about an individual who is the subject of the background study is correct and must provide the information on forms or in a format prescribed by the commissioner.

(b) The information collected under subdivision 1 about an individual who is the subject of a completed background study may only be viewable by an entity that initiates a subsequent background study on that individual under NETStudy 2.0 after the entity has paid the applicable fee for the study and has provided the individual with the privacy notice in subdivision 2c.

Sec. 16. Minnesota Statutes 2020, section 245C.05, subdivision 2a, is amended to read:

Subd. 2a. **County or private agency.** For background studies related to child foster care when the applicant or license holder resides in the home where child foster care services are provided, county and private agencies initiating the background study must collect the information under subdivision 1 and forward it to the commissioner.

Sec. 17. Minnesota Statutes 2020, section 245C.05, subdivision 2b, is amended to read:

Subd. 2b. **County agency to collect and forward information to commissioner.** (a) For background studies related to all family adult day services and to adult foster care when the adult foster care license holder resides in the adult foster care residence, the county agency or private agency initiating the background study must collect the information required under subdivision 1 and forward it to the commissioner.

(b) Upon implementation of NETStudy 2.0, for background studies related to family child care and legal nonlicensed child care authorized under chapter 119B, the county agency initiating the background study must collect the information required under subdivision 1 and provide the information to the commissioner.

Sec. 18. Minnesota Statutes 2020, section 245C.05, subdivision 2c, is amended to read:

Subd. 2c. **Privacy notice to background study subject.** (a) Prior to initiating each background study, the entity initiating the study must provide the commissioner's privacy notice to the background study subject required under section 13.04, subdivision 2. The notice must be available through the commissioner's electronic NETStudy and NETStudy 2.0 systems and shall include the information in paragraphs (b) and (c).

(b) The background study subject shall be informed that any previous background studies that received a set-aside will be reviewed, and without further contact with the background study subject, the commissioner may notify the agency that initiated the subsequent background study:

(1) that the individual has a disqualification that has been set aside for the program or agency that initiated the study;

(2) the reason for the disqualification; and

(3) that information about the decision to set aside the disqualification will be available to the license holder upon request without the consent of the background study subject.

(c) The background study subject must also be informed that:

(1) the subject's fingerprints collected for purposes of completing the background study under this chapter must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or by the commissioner. The Federal Bureau of Investigation will ~~only retain fingerprints of subjects with a criminal history~~ not retain background study subjects' fingerprints;

(2) effective upon implementation of NETStudy 2.0, the subject's photographic image will be retained by the commissioner, and if the subject has provided the subject's Social Security number for purposes of the background study, the photographic image will be available to prospective employers and agencies initiating background studies under this chapter to verify the identity of the subject of the background study;

(3) the commissioner's authorized fingerprint collection vendor or vendors shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized fingerprint collection vendor or vendors shall retain no more than the subject's name and the date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities;

(4) the commissioner shall provide the subject notice, as required in section 245C.17, subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

(5) the subject may request in writing a report listing the entities that initiated a background study on the individual as provided in section 245C.17, subdivision 1, paragraph (b);

(6) the subject may request in writing that information used to complete the individual's background study in NETStudy 2.0 be destroyed if the requirements of section 245C.051, paragraph (a), are met; and

(7) notwithstanding clause (6), the commissioner shall destroy:

(i) the subject's photograph after a period of two years when the requirements of section 245C.051, paragraph (c), are met; and

(ii) any data collected on a subject under this chapter after a period of two years following the individual's death as provided in section 245C.051, paragraph (d).

Sec. 19. Minnesota Statutes 2020, section 245C.05, subdivision 2d, is amended to read:

Subd. 2d. **Fingerprint data notification.** The commissioner of human services shall notify all background study subjects under this chapter that the Department of Human Services, Department of Public Safety, and the Bureau of Criminal Apprehension do not retain fingerprint data after a background study is completed, and that the Federal Bureau of Investigation ~~only retains the fingerprints of subjects who have a criminal history~~ does not retain background study subjects' fingerprints.

Sec. 20. Minnesota Statutes 2020, section 245C.05, subdivision 4, is amended to read:

Subd. 4. **Electronic transmission.** (a) For background studies conducted by the Department of Human Services, the commissioner shall implement a secure system for the electronic transmission of:

(1) background study information to the commissioner;

(2) background study results to the license holder;

(3) background study ~~results~~ information obtained under this section and section 245C.08 to counties and private agencies for background studies conducted by the commissioner for child foster care, including a summary of nondisqualifying results, except as prohibited by law; and

(4) background study results to county agencies for background studies conducted by the commissioner for adult foster care and family adult day services and, upon implementation of NETStudy 2.0, family child care and legal nonlicensed child care authorized under chapter 119B.

(b) Unless the commissioner has granted a hardship variance under paragraph (c), a license holder or an applicant must use the electronic transmission system known as

NETStudy or NETStudy 2.0 to submit all requests for background studies to the commissioner as required by this chapter.

(c) A license holder or applicant whose program is located in an area in which high-speed Internet is inaccessible may request the commissioner to grant a variance to the electronic transmission requirement.

(d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under this subdivision.

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

Sec. 21. Minnesota Statutes 2020, section 245C.08, subdivision 3, is amended to read:

Subd. 3. **Arrest and investigative information.** (a) For any background study completed under this section, if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual, the commissioner also may review arrest and investigative information from:

(1) the Bureau of Criminal Apprehension;

(2) the commissioners of health and human services;

(3) a county attorney;

(4) a county sheriff;

(5) a county agency;

(6) a local chief of police;

(7) other states;

(8) the courts;

(9) the Federal Bureau of Investigation;

(10) the National Criminal Records Repository; and

(11) criminal records from other states.

(b) Except when specifically required by law, the commissioner is not required to conduct more than one review of a subject's records from the Federal Bureau of Investigation if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the entity that initiated the background study.

(c) If the commissioner conducts a national criminal history record check when required by law and uses the information from the national criminal history record check to make a disqualification determination, the data obtained is private data and cannot be shared with ~~county agencies,~~ private agencies~~,~~ or prospective employers of the background study subject.

(d) If the commissioner conducts a national criminal history record check when required by law and uses the information from the national criminal history record check to make a disqualification determination, the license holder or entity that submitted the study is not required to obtain a copy of the background study subject's disqualification letter under section 245C.17, subdivision 3.

Sec. 22. Minnesota Statutes 2020, section 245C.08, is amended by adding a subdivision to read:

Subd. 5. **Authorization.** The commissioner of human services shall be authorized to receive information under this chapter.

Sec. 23. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 1b. **Background study fees.** (a) The commissioner shall recover the cost of background studies. Except as otherwise provided in subdivisions 1c and 1d, the fees collected under this section shall be appropriated to the commissioner for the purpose of conducting background studies under this chapter. Fees under this section are charges under section 16A.1283, paragraph (b), clause (3).

(b) Background study fees may include:

(1) a fee to compensate the commissioner's authorized fingerprint collection vendor or vendors for obtaining and processing a background study subject's classifiable fingerprints and photograph pursuant to subdivision 1c; and

(2) a separate fee under subdivision 1c to complete a review of background-study-related records as authorized under this chapter.

(c) Fees charged under paragraph (b) may be paid in whole or part when authorized by law by a state agency or board; by state court administration; by a service provider, employer, license holder, or other organization that initiates the background study; by the commissioner or other organization with duly appropriated funds; by a background study subject; or by some combination of these sources.

Sec. 24. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 1c. **Fingerprint and photograph processing fees.** The commissioner shall enter into a contract with a qualified vendor or vendors to obtain and process a background study subject's classifiable fingerprints and photograph as required by section 245C.05. The commissioner may, at their discretion, directly collect fees and reimburse the commissioner's authorized fingerprint collection vendor for the vendor's services or require the vendor to collect the fees. The authorized vendor is responsible for reimbursing the vendor's subcontractors at a rate specified in the contract with the commissioner.

Sec. 25. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 1d. **Background studies fee schedule.** (a) By March 1 each year, the commissioner shall publish a schedule of fees sufficient to administer and conduct background studies under this chapter. The published schedule of fees shall be effective on July 1 each year.

(b) Fees shall be based on the actual costs of administering and conducting background studies, including payments to external agencies, department indirect cost payments under section 16A.127, processing fees, and costs related to due process.

(c) The commissioner shall publish a notice of fees by posting fee amounts on the department website. The notice shall specify the actual costs that comprise the fees including the categories described in paragraph (b).

(d) The published schedule of fees shall remain in effect from July 1 to June 30 each year.

(e) The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies, alternative background studies, and criminal background checks.

EFFECTIVE DATE. This section is effective July 1, 2021. The commissioner of human services shall publish the initial fee schedule on the Department of Human Services website on July 1, 2021, and the initial fee schedule is effective September 1, 2021.

Sec. 26. Minnesota Statutes 2020, section 245C.10, subdivision 15, is amended to read:

Subd. 15. **Guardians and conservators.** The ~~commissioner shall recover the cost of conducting background studies for guardians and conservators under section 524.5-118 through a fee of no more than $110 per study. The fees collected under this subdivision are~~

~~appropriated to the commissioner for the purpose of conducting background studies.~~ fee for conducting an alternative background study for appointment of a professional guardian or conservator must be paid by the guardian or conservator. In other cases, the fee must be paid as follows:

(1) if the matter is proceeding in forma pauperis, the fee must be paid as an expense for purposes of section 524.5-502, paragraph (a);

(2) if there is an estate of the ward or protected person, the fee must be paid from the estate; or

(3) in the case of a guardianship or conservatorship of a person that is not proceeding in forma pauperis, the fee must be paid by the guardian, conservator, or the court.

Sec. 27. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 17. **Early intensive developmental and behavioral intervention providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 15, for the purposes of early intensive developmental and behavioral intervention under section 256B.0949, through a fee of no more than $20 per study charged to the enrolled agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

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

Sec. 28. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 18. **Applicants, licensees, and other occupations regulated by commissioner of health.** The applicant or license holder is responsible for paying to the Department of Human Services all fees associated with the preparation of the fingerprints, the criminal records check consent form, and the criminal background check.

Sec. 29. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 19. **Occupations regulated by MNsure.** The commissioner shall set fees to recover the cost of background studies and criminal background checks initiated by MNsure under sections 62V.05 and 245C.031. The fee amount shall be established through interagency agreement between the commissioner and the board of MNsure or its designee.

The fees collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks.

Sec. 30. Minnesota Statutes 2020, section 245C.13, subdivision 2, is amended to read:

Subd. 2. **Activities pending completion of background study.** The subject of a background study may not perform any activity requiring a background study under paragraph (c) until the commissioner has issued one of the notices under paragraph (a).

(a) Notices from the commissioner required prior to activity under paragraph (c) include:

(1) a notice of the study results under section 245C.17 stating that:

(i) the individual is not disqualified; or

(ii) more time is needed to complete the study but the individual is not required to be removed from direct contact or access to people receiving services prior to completion of the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice that more time is needed to complete the study must also indicate whether the individual is required to be under continuous direct supervision prior to completion of the background study. When more time is necessary to complete a background study of an individual affiliated with a Title IV-E eligible children's residential facility or foster residence setting, the individual may not work in the facility or setting regardless of whether or not the individual is supervised;

(2) a notice that a disqualification has been set aside under section 245C.23; or

(3) a notice that a variance has been granted related to the individual under section 245C.30.

(b) For a background study affiliated with a licensed child care center or certified license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii), must require the individual to be under continuous direct supervision prior to completion of the background study except as permitted in subdivision 3.

(c) Activities prohibited prior to receipt of notice under paragraph (a) include:

(1) being issued a license;

(2) living in the household where the licensed program will be provided;

(3) providing direct contact services to persons served by a program unless the subject is under continuous direct supervision;

(4) having access to persons receiving services if the background study was completed under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2), (5), or (6), unless the subject is under continuous direct supervision;

(5) for licensed child care centers and certified license-exempt child care centers, providing direct contact services to persons served by the program; ~~or~~

(6) for children's residential facilities or foster residence settings, working in the facility or setting~~.~~; or

(7) for background studies affiliated with a personal care provider organization, except as provided in section 245C.03, subdivision 3b, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study of the personal care assistant under this chapter and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22.

Sec. 31. Minnesota Statutes 2020, section 245C.14, subdivision 1, is amended to read:

Subdivision 1. **Disqualification from direct contact.** (a) The commissioner shall disqualify an individual who is the subject of a background study from any position allowing direct contact with persons receiving services from the license holder or entity identified in section 245C.03, upon receipt of information showing, or when a background study completed under this chapter shows any of the following:

(1) a conviction of, admission to, or Alford plea to one or more crimes listed in section 245C.15, regardless of whether the conviction or admission is a felony, gross misdemeanor, or misdemeanor level crime;

(2) a preponderance of the evidence indicates the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, regardless of whether the preponderance of the evidence is for a felony, gross misdemeanor, or misdemeanor level crime; or

(3) an investigation results in an administrative determination listed under section 245C.15, subdivision 4, paragraph (b).

(b) No individual who is disqualified following a background study under section 245C.03, subdivisions 1 and 2, may be retained in a position involving direct contact with persons served by a program or entity identified in section 245C.03, unless the commissioner has provided written notice under section 245C.17 stating that:

(1) the individual may remain in direct contact during the period in which the individual may request reconsideration as provided in section 245C.21, subdivision 2;

(2) the commissioner has set aside the individual's disqualification for that program or entity identified in section 245C.03, as provided in section 245C.22, subdivision 4; or

(3) the license holder has been granted a variance for the disqualified individual under section 245C.30.

(c) Notwithstanding paragraph (a), for the purposes of a background study affiliated with a licensed family foster setting, the commissioner shall disqualify an individual who is the subject of a background study from any position allowing direct contact with persons receiving services from the license holder or entity identified in section 245C.03, upon receipt of information showing or when a background study completed under this chapter shows reason for disqualification under section 245C.15, subdivision 4a.

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

Sec. 32. Minnesota Statutes 2020, section 245C.14, is amended by adding a subdivision to read:

Subd. 4. **Disqualification from working in licensed child care centers or certified license-exempt child care centers.** (a) For a background study affiliated with a licensed child care center or certified license-exempt child care center, if an individual is disqualified from direct contact under subdivision 1, the commissioner must also disqualify the individual from working in any position regardless of whether the individual would have direct contact with or access to children served in the licensed child care center or certified license-exempt child care center and from having access to a person receiving services from the center.

(b) Notwithstanding any other requirement of this chapter, for a background study affiliated with a licensed child care center or a certified license-exempt child care center, if an individual is disqualified, the individual may not work in the child care center until the commissioner has issued a notice stating that:

(1) the individual is not disqualified;

(2) a disqualification has been set aside under section 245C.23; or

(3) a variance has been granted related to the individual under section 245C.30.

Sec. 33. Minnesota Statutes 2020, section 245C.15, is amended by adding a subdivision to read:

Subd. 4a. **Licensed family foster setting disqualifications.** (a) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting, regardless of how much time has passed, an individual is disqualified under section 245C.14 if the individual committed an act that resulted in a felony-level conviction for sections: 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.2112 (criminal vehicular homicide); 609.221 (assault in the first degree); 609.223, subdivision 2 (assault in the third degree, past pattern of child abuse); 609.223, subdivision 3 (assault in the third degree, victim under four); a felony offense under sections 609.2242 and 609.2243 (domestic assault, spousal abuse, child abuse or neglect, or a crime against children); 609.2247 (domestic assault by strangulation); 609.2325 (criminal abuse of a vulnerable adult resulting in the death of a vulnerable adult); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.255 (false imprisonment); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.322, subdivision 1 (solicitation, inducement, and promotion of prostitution; sex trafficking in the first degree); 609.324, subdivision 1 (other prohibited acts; engaging in, hiring, or agreeing to hire minor to engage in prostitution); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory conduct); 609.352 (solicitation of children to engage in sexual conduct); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.561 (arson in the first degree); 609.582, subdivision 1 (burglary in the first degree); 609.746 (interference with privacy); 617.23 (indecent exposure); 617.246 (use of minors in sexual performance prohibited); or 617.247 (possession of pictorial representations of minors).

(b) Notwithstanding subdivisions 1 to 4, for the purposes of a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14, regardless of how much time has passed, if the individual:

(1) committed an action under paragraph (d) that resulted in death or involved sexual abuse, as defined in section 260E.03, subdivision 20;

(2) committed an act that resulted in a gross misdemeanor-level conviction for section 609.3451 (criminal sexual conduct in the fifth degree);

(3) committed an act against or involving a minor that resulted in a felony-level conviction for: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree); or 609.224 (assault in the fifth degree); or

(4) committed an act that resulted in a misdemeanor or gross misdemeanor-level conviction for section 617.293 (dissemination and display of harmful materials to minors).

(c) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14 if less than 20 years have passed since the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or if the individual consented to a termination of parental rights under section 260C.301, subdivision 1, paragraph (a), to settle a petition to involuntarily terminate parental rights. An individual is disqualified under section 245C.14 if less than 20 years have passed since the termination of the individual's parental rights in any other state or country, where the conditions for the individual's termination of parental rights are substantially similar to the conditions in section 260C.301, subdivision 1, paragraph (b).

(d) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14 if less than five years have passed since a felony-level violation for sections: 152.021 (controlled substance crime in the first degree); 152.022 (controlled substance crime in the second degree); 152.023 (controlled substance crime in the third degree); 152.024 (controlled substance crime in the fourth degree); 152.025 (controlled substance crime in the fifth degree); 152.0261 (importing controlled substances across state borders); 152.0262, subdivision 1, paragraph (b) (possession of substance with intent to manufacture methamphetamine); 152.027, subdivision 6, paragraph (c) (sale or possession of synthetic cannabinoids); 152.096 (conspiracies prohibited); 152.097 (simulated controlled substances); 152.136 (anhydrous ammonia; prohibited conduct; criminal penalties; civil liabilities); 152.137 (methamphetamine-related

crimes involving children or vulnerable adults); 169A.24 (felony first-degree driving while impaired); 243.166 (violation of predatory offender registration requirements); 609.2113 (criminal vehicular operation; bodily harm); 609.2114 (criminal vehicular operation; unborn child); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult not resulting in the death of a vulnerable adult); 609.233 (criminal neglect); 609.235 (use of drugs to injure or facilitate a crime); 609.24 (simple robbery); 609.322, subdivision 1a (solicitation, inducement, and promotion of prostitution; sex trafficking in the second degree); 609.498, subdivision 1 (tampering with a witness in the first degree); 609.498, subdivision 1b (aggravated first-degree witness tampering); 609.562 (arson in the second degree); 609.563 (arson in the third degree); 609.582, subdivision 2 (burglary in the second degree); 609.66 (felony dangerous weapons); 609.687 (adulteration); 609.713 (terroristic threats); 609.749, subdivision 3, 4, or 5 (felony-level harassment or stalking); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); or 624.713 (certain people not to possess firearms).

(e) Notwithstanding subdivisions 1 to 4, except as provided in paragraph (a), for a background study affiliated with a licensed family child foster care license, an individual is disqualified under section 245C.14 if less than five years have passed since:

(1) a felony-level violation for an act not against or involving a minor that constitutes: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the fifth degree);

(2) a violation of an order for protection under section 518B.01, subdivision 14;

(3) a determination or disposition of the individual's failure to make required reports under section 260E.06 or 626.557, subdivision 3, for incidents in which the final disposition under chapter 260E or section 626.557 was substantiated maltreatment and the maltreatment was recurring or serious;

(4) a determination or disposition of the individual's substantiated serious or recurring maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under chapter 260E or section 626.557 and meet the definition of serious maltreatment or recurring maltreatment;

(5) a gross misdemeanor-level violation for sections: 609.224, subdivision 2 (assault in the fifth degree); 609.2242 and 609.2243 (domestic assault); 609.233 (criminal neglect);

609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.746 (interference with privacy); 609.749 (stalking); or 617.23 (indecent exposure); or

(6) committing an act against or involving a minor that resulted in a misdemeanor-level violation of section 609.224, subdivision 1 (assault in the fifth degree).

(f) For purposes of this subdivision, the disqualification begins from:

(1) the date of the alleged violation, if the individual was not convicted;

(2) the date of conviction, if the individual was convicted of the violation but not committed to the custody of the commissioner of corrections; or

(3) the date of release from prison, if the individual was convicted of the violation and committed to the custody of the commissioner of corrections.

Notwithstanding clause (3), if the individual is subsequently reincarcerated for a violation of the individual's supervised release, the disqualification begins from the date of release from the subsequent incarceration.

(g) An individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota Statutes, permanently disqualifies the individual under section 245C.14. An individual is disqualified under section 245C.14 if less than five years have passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (d) and (e).

(h) An individual's offense in any other state or country, where the elements of the offense are substantially similar to any of the offenses listed in paragraphs (a) and (b), permanently disqualifies the individual under section 245C.14. An individual is disqualified under section 245C.14 if less than five years has passed since an offense in any other state or country, the elements of which are substantially similar to the elements of any offense listed in paragraphs (d) and (e).

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

Sec. 34. Minnesota Statutes 2020, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people receiving services.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

(1) the recency of the disqualifying characteristic;

(2) the recency of discharge from probation for the crimes;

(3) the number of disqualifying characteristics;

(4) the intrusiveness or violence of the disqualifying characteristic;

(5) the vulnerability of the victim involved in the disqualifying characteristic;

(6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact;

(7) whether the individual has a disqualification from a previous background study that has not been set aside; ~~and~~

(8) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 1, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense in the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with, or access to, persons receiving services from the program and from working in a children's residential facility or foster residence setting~~.~~; and

(9) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 2, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense during the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with or access to persons receiving services from the center and from working in a licensed child care center or certified license-exempt child care center.

(c) This section does not apply when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the subject is determined to be responsible for substantiated maltreatment under section 626.557 or chapter 260E.

(d) This section does not apply to a background study related to an initial application for a child foster family setting license.

(e) Except for paragraph (f), this section does not apply to a background study that is also subject to the requirements under section 256B.0659, subdivisions 11 and 13, for a

personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1.

(f) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

Sec. 35. Minnesota Statutes 2020, section 245C.16, subdivision 2, is amended to read:

Subd. 2. **Findings.** (a) After evaluating the information immediately available under subdivision 1, the commissioner may have reason to believe one of the following:

(1) the individual poses an imminent risk of harm to persons served by the program where the individual studied will have direct contact or access to persons served by the program or where the individual studied will work;

(2) the individual poses a risk of harm requiring continuous, direct supervision while providing direct contact services during the period in which the subject may request a reconsideration; or

(3) the individual does not pose an imminent risk of harm or a risk of harm requiring continuous, direct supervision while providing direct contact services during the period in which the subject may request a reconsideration.

(b) After determining an individual's risk of harm under this section, the commissioner must notify the subject of the background study and the applicant or license holder as required under section 245C.17.

(c) For Title IV-E eligible children's residential facilities and foster residence settings, the commissioner is prohibited from making the findings in paragraph (a), clause (2) or (3).

(d) For licensed child care centers or certified license-exempt child care centers, the commissioner is prohibited from making the findings in paragraph (a), clause (2) or (3).

Sec. 36. Minnesota Statutes 2020, section 245C.17, subdivision 1, is amended to read:

Subdivision 1. **Time frame for notice of study results and auditing system access.** (a) Within three working days after the commissioner's receipt of a request for a background study submitted through the commissioner's NETStudy or NETStudy 2.0 system, the commissioner shall notify the background study subject and the license holder or other

entity as provided in this chapter in writing or by electronic transmission of the results of the study or that more time is needed to complete the study. The notice to the individual shall include the identity of the entity that initiated the background study.

(b) Before being provided access to NETStudy 2.0, the license holder or other entity under section 245C.04 shall sign an acknowledgment of responsibilities form developed by the commissioner that includes identifying the sensitive background study information person, who must be an employee of the license holder or entity. All queries to NETStudy 2.0 are electronically recorded and subject to audit by the commissioner. The electronic record shall identify the specific user. A background study subject may request in writing to the commissioner a report listing the entities that initiated a background study on the individual.

(c) When the commissioner has completed a prior background study on an individual that resulted in an order for immediate removal and more time is necessary to complete a subsequent study, the notice that more time is needed that is issued under paragraph (a) shall include an order for immediate removal of the individual from any position allowing direct contact with or access to people receiving services and from working in a children's residential facility ~~or~~, foster residence setting, child care center, or certified license-exempt child care center pending completion of the background study.

Sec. 37. Minnesota Statutes 2020, section 245C.17, is amended by adding a subdivision to read:

Subd. 8. **Disqualification notice to child care centers and certified license-exempt child care centers.** (a) For child care centers and certified license-exempt child care centers, all notices under this section that order the license holder to immediately remove the individual studied from any position allowing direct contact with, or access to a person served by the center, must also order the license holder to immediately remove the individual studied from working in any position regardless of whether the individual would have direct contact with or access to children served in the center.

(b) For child care centers and certified license-exempt child care centers, notices under this section must not allow an individual to work in the center.

Sec. 38. Minnesota Statutes 2020, section 245C.18, is amended to read:

245C.18 OBLIGATION TO REMOVE DISQUALIFIED INDIVIDUAL FROM DIRECT CONTACT AND FROM WORKING IN A PROGRAM, FACILITY, ~~OR~~ SETTING, OR CENTER.

(a) Upon receipt of notice from the commissioner, the license holder must remove a disqualified individual from direct contact with persons served by the licensed program if:

(1) the individual does not request reconsideration under section 245C.21 within the prescribed time;

(2) the individual submits a timely request for reconsideration, the commissioner does not set aside the disqualification under section 245C.22, subdivision 4, and the individual does not submit a timely request for a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14; or

(3) the individual submits a timely request for a hearing under sections 245C.27 and 256.045, or 245C.28 and chapter 14, and the commissioner does not set aside or rescind the disqualification under section 245A.08, subdivision 5, or 256.045.

(b) For children's residential facility and foster residence setting license holders, upon receipt of notice from the commissioner under paragraph (a), the license holder must also remove the disqualified individual from working in the program, facility, or setting and from access to persons served by the licensed program.

(c) For Title IV-E eligible children's residential facility and foster residence setting license holders, upon receipt of notice from the commissioner under paragraph (a), the license holder must also remove the disqualified individual from working in the program and from access to persons served by the program and must not allow the individual to work in the facility or setting until the commissioner has issued a notice stating that:

(1) the individual is not disqualified;

(2) a disqualification has been set aside under section 245C.23; or

(3) a variance has been granted related to the individual under section 245C.30.

(d) For licensed child care center and certified license-exempt child care center license holders, upon receipt of notice from the commissioner under paragraph (a), the license holder must remove the disqualified individual from working in any position regardless of whether the individual would have direct contact with or access to children served in the

center and from having access to persons served by the center and must not allow the individual to work in the center until the commissioner has issued a notice stating that:

(1) the individual is not disqualified;

(2) a disqualification has been set aside under section 245C.23; or

(3) a variance has been granted related to the individual under section 245C.30.

Sec. 39. Minnesota Statutes 2020, section 245C.24, subdivision 2, is amended to read:

Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in paragraphs (b) to ~~(e)~~ (f), the commissioner may not set aside the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 1.

(b) For an individual in the chemical dependency or corrections field who was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose disqualification was set aside prior to July 1, 2005, the commissioner must consider granting a variance pursuant to section 245C.30 for the license holder for a program dealing primarily with adults. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the license holder that was subject to the prior set-aside decision addressing the individual's quality of care to children or vulnerable adults and the circumstances of the individual's departure from that service.

(c) If an individual who requires a background study for nonemergency medical transportation services under section 245C.03, subdivision 12, was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and if more than 40 years have passed since the discharge of the sentence imposed, the commissioner may consider granting a set-aside pursuant to section 245C.22. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the employer. This paragraph does not apply to a person disqualified based on a violation of sections 243.166; 609.185 to 609.205; 609.25; 609.342 to 609.3453; 609.352; 617.23, subdivision 2, clause (1), or 3, clause (1); 617.246; or 617.247.

(d) When a licensed foster care provider adopts an individual who had received foster care services from the provider for over six months, and the adopted individual is required to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30 to permit the adopted individual with a permanent disqualification to remain affiliated with

the license holder under the conditions of the variance when the variance is recommended by the county of responsibility for each of the remaining individuals in placement in the home and the licensing agency for the home.

(e) For an individual 18 years of age or older affiliated with a licensed family foster setting, the commissioner must not set aside or grant a variance for the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 4a, paragraphs (a) and (b).

(f) In connection with a family foster setting license, the commissioner may grant a variance to the disqualification for an individual who is under 18 years of age at the time the background study is submitted.

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

Sec. 40. Minnesota Statutes 2020, section 245C.24, subdivision 3, is amended to read:

Subd. 3. **Ten-year bar to set aside disqualification.** (a) The commissioner may not set aside the disqualification of an individual in connection with a license to provide family child care for children~~, foster care for children in the provider's home,~~ or foster care or day care services for adults in the provider's home if: (1) less than ten years has passed since the discharge of the sentence imposed, if any, for the offense; or (2) when disqualified based on a preponderance of evidence determination under section 245C.14, subdivision 1, paragraph (a), clause (2), or an admission under section 245C.14, subdivision 1, paragraph (a), clause (1), and less than ten years has passed since the individual committed the act or admitted to committing the act, whichever is later; and (3) the individual has committed a violation of any of the following offenses: sections 609.165 (felon ineligible to possess firearm); criminal vehicular homicide or criminal vehicular operation causing death under 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (aiding suicide or aiding attempted suicide); felony violations under 609.223 or 609.2231 (assault in the third or fourth degree); 609.229 (crimes committed for benefit of a gang); 609.713 (terroristic threats); 609.235 (use of drugs to injure or to facilitate crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.562 (arson in the second degree); 609.71 (riot); 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a witness); burglary in the first or second degree under 609.582 (burglary); 609.66 (dangerous weapon); 609.665 (spring guns); 609.67 (machine guns and short-barreled shotguns); 609.749, subdivision 2 (gross misdemeanor harassment); 152.021 or 152.022 (controlled substance crime in the first or second degree); 152.023, subdivision 1, clause (3) or (4) or

subdivision 2, clause (4) (controlled substance crime in the third degree); 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree); 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report); 609.265 (abduction); 609.2664 to 609.2665 (manslaughter of an unborn child in the first or second degree); 609.267 to 609.2672 (assault of an unborn child in the first, second, or third degree); 609.268 (injury or death of an unborn child in the commission of a crime); repeat offenses under 617.23 (indecent exposure); 617.293 (disseminating or displaying harmful material to minors); a felony-level conviction involving alcohol or drug use, a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts); a gross misdemeanor offense under 609.378 (neglect or endangerment of a child); a gross misdemeanor offense under 609.377 (malicious punishment of a child); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or 624.713 (certain persons not to possess firearms); or Minnesota Statutes 2012, section 609.21.

(b) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a) as each of these offenses is defined in Minnesota Statutes.

(c) The commissioner may not set aside the disqualification of an individual if less than ten years have passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraph (a).

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

Sec. 41. Minnesota Statutes 2020, section 245C.24, subdivision 4, is amended to read:

Subd. 4. **Seven-year bar to set aside disqualification.** The commissioner may not set aside the disqualification of an individual in connection with a license to provide family child care for children~~, foster care for children in the provider's home,~~ or foster care or day care services for adults in the provider's home if within seven years preceding the study:

(1) the individual committed an act that constitutes maltreatment of a child under sections 260E.24, subdivisions 1, 2, and 3, and 260E.30, subdivisions 1, 2, and 4, and the maltreatment resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial

mental or emotional harm as supported by competent psychological or psychiatric evidence; or

(2) the individual was determined under section 626.557 to be the perpetrator of a substantiated incident of maltreatment of a vulnerable adult that resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional harm as supported by competent psychological or psychiatric evidence.

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

Sec. 42. Minnesota Statutes 2020, section 245C.24, is amended by adding a subdivision to read:

Subd. 6. **Five-year bar to set aside disqualification; family foster setting.** (a) The commissioner shall not set aside or grant a variance for the disqualification of an individual 18 years of age or older in connection with a foster family setting license if within five years preceding the study the individual is convicted of a felony in section 245C.15, subdivision 4a, paragraph (d).

(b) In connection with a foster family setting license, the commissioner may set aside or grant a variance to the disqualification for an individual who is under 18 years of age at the time the background study is submitted.

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

Sec. 43. Minnesota Statutes 2020, section 245C.32, subdivision 1a, is amended to read:

Subd. 1a. **NETStudy 2.0 system.** (a) The commissioner shall design, develop, and test the NETStudy 2.0 system and implement it no later than September 1, 2015.

(b) The NETStudy 2.0 system developed and implemented by the commissioner shall incorporate and meet all applicable data security standards and policies required by the Federal Bureau of Investigation (FBI), Department of Public Safety, Bureau of Criminal Apprehension, and the Office of MN.IT Services. The system shall meet all required standards for encryption of data at the database level as well as encryption of data that travels electronically among agencies initiating background studies, the commissioner's authorized fingerprint collection vendor or vendors, the commissioner, the Bureau of Criminal Apprehension, and in cases involving national criminal record checks, the FBI.

(c) The data system developed and implemented by the commissioner shall incorporate a system of data security that allows the commissioner to control access to the data field level by the commissioner's employees. The commissioner shall establish that employees

have access to the minimum amount of private data on any individual as is necessary to perform their duties under this chapter.

(d) The commissioner shall oversee regular quality and compliance audits of the authorized fingerprint collection vendor or vendors.

Sec. 44. Minnesota Statutes 2020, section 256B.0949, is amended by adding a subdivision to read:

Subd. 16a. **Background studies.** The requirements for background studies under this section shall be met by an early intensive developmental and behavioral intervention services agency through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 15, and 245C.10, subdivision 17.

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

Sec. 45. Minnesota Statutes 2020, section 260C.215, subdivision 4, is amended to read:

Subd. 4. **Duties of commissioner.** The commissioner of human services shall:

(1) provide practice guidance to responsible social services agencies and licensed child-placing agencies that reflect federal and state laws and policy direction on placement of children;

(2) develop criteria for determining whether a prospective adoptive or foster family has the ability to understand and validate the child's cultural background;

(3) provide a standardized training curriculum for adoption and foster care workers and administrators who work with children. Training must address the following objectives:

(i) developing and maintaining sensitivity to all cultures;

(ii) assessing values and their cultural implications;

(iii) making individualized placement decisions that advance the best interests of a particular child under section 260C.212, subdivision 2; and

(iv) issues related to cross-cultural placement;

(4) provide a training curriculum for all prospective adoptive and foster families that prepares them to care for the needs of adoptive and foster children taking into consideration the needs of children outlined in section 260C.212, subdivision 2, paragraph (b), and, as necessary, preparation is continued after placement of the child and includes the knowledge and skills related to reasonable and prudent parenting standards for the participation of the

child in age or developmentally appropriate activities, according to section 260C.212, subdivision 14;

(5) develop and provide to responsible social services agencies and licensed child-placing agencies a home study format to assess the capacities and needs of prospective adoptive and foster families. The format must address problem-solving skills; parenting skills; evaluate the degree to which the prospective family has the ability to understand and validate the child's cultural background, and other issues needed to provide sufficient information for agencies to make an individualized placement decision consistent with section 260C.212, subdivision 2. For a study of a prospective foster parent, the format must also address the capacity of the prospective foster parent to provide a safe, healthy, smoke-free home environment. If a prospective adoptive parent has also been a foster parent, any update necessary to a home study for the purpose of adoption may be completed by the licensing authority responsible for the foster parent's license. If a prospective adoptive parent with an approved adoptive home study also applies for a foster care license, the license application may be made with the same agency which provided the adoptive home study; ~~and~~

(6) consult with representatives reflecting diverse populations from the councils established under sections 3.922 and 15.0145, and other state, local, and community organizations~~.~~; and

(7) establish family foster setting licensing guidelines for county agencies and private agencies designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04. Guidelines that the commissioner establishes under this paragraph shall be considered directives of the commissioner under section 245A.16.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 46. Laws 2020, First Special Session chapter 7, section 1, as amended by Laws 2020, Third Special Session chapter 1, section 3, is amended by adding a subdivision to read:

Subd. 5. **Waivers and modifications; extension for 180 days.** When the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, waiver CV23: modifying background study requirements, issued by the commissioner of human services pursuant to Executive Orders 20-11 and 20-12, including any amendments to the modification issued before the peacetime emergency expires, shall remain in effect for 180 days after the peacetime emergency ends.

EFFECTIVE DATE. This section is effective the day following final enactment or retroactively from the date the peacetime emergency declared by the governor in response to the COVID-19 outbreak ends, whichever is earlier.

Sec. 47. **CHILD FOSTER CARE LICENSING GUIDELINES.**

By July 1, 2023, the commissioner of human services shall, in consultation with stakeholders with expertise in child protection and children's behavioral health, develop family foster setting licensing guidelines for county agencies and private agencies that perform licensing functions. Stakeholders include but are not limited to child advocates, representatives from community organizations, representatives of the state ethnic councils, the ombudsperson for families, family foster setting providers, youth who have experienced family foster setting placements, county child protection staff, and representatives of county and private licensing agencies.

Sec. 48. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 245C.02, so that the subdivisions are alphabetical. The revisor shall correct any cross-references that arise as a result of the renumbering.

Sec. 49. **REPEALER.**

Minnesota Statutes 2020, section 245C.10, subdivisions 2, 2a, 3, 4, 5, 6, 7, 8, 9, 9a, 10, 11, 12, 13, 14, and 16, are repealed.

ARTICLE 3
HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2020, section 62J.495, subdivision 1, is amended to read:

Subdivision 1. **Implementation.** The commissioner of health, in consultation with the e-Health Advisory Committee, shall develop uniform standards to be used for the interoperable electronic health records system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, and updated on an ongoing basis. ~~The commissioner shall include an update on standards development as part of an annual report to the legislature.~~ Individual health care providers in private practice with no other providers and health care providers that do not accept reimbursement from a group purchaser, as defined in section 62J.03, subdivision 6, are excluded from the requirements of this section.

Sec. 2. Minnesota Statutes 2020, section 62J.495, subdivision 2, is amended to read:

Subd. 2. **E-Health Advisory Committee.** (a) The commissioner shall establish an e-Health Advisory Committee governed by section 15.059 to advise the commissioner on the following matters:

(1) assessment of the adoption and effective use of health information technology by the state, licensed health care providers and facilities, and local public health agencies;

(2) recommendations for implementing a statewide interoperable health information infrastructure, to include estimates of necessary resources, and for determining standards for clinical data exchange, clinical support programs, patient privacy requirements, and maintenance of the security and confidentiality of individual patient data;

(3) recommendations for encouraging use of innovative health care applications using information technology and systems to improve patient care and reduce the cost of care, including applications relating to disease management and personal health management that enable remote monitoring of patients' conditions, especially those with chronic conditions; and

(4) other related issues as requested by the commissioner.

(b) The members of the e-Health Advisory Committee shall include the commissioners, or commissioners' designees, of health, human services, administration, and commerce and additional members to be appointed by the commissioner to include persons representing Minnesota's local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise in health information technology, and other stakeholders as identified by the commissioner to fulfill the requirements of section 3013, paragraph (g), of the HITECH Act.

(c) ~~The commissioner shall prepare and issue an annual report not later than January 30 of each year outlining progress to date in implementing a statewide health information infrastructure and recommending action on policy and necessary resources to continue the promotion of adoption and effective use of health information technology.~~

~~(d)~~ This subdivision expires June 30, ~~2021~~ 2031.

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

Sec. 3. Minnesota Statutes 2020, section 62J.495, subdivision 3, is amended to read:

Subd. 3. **Interoperable electronic health record requirements.** (a) Hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(b) The electronic health record must be a qualified electronic health record.

(c) The electronic health record must be certified by the Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(d) The electronic health record must meet the standards established according to section 3004 of the HITECH Act as applicable.

(e) The electronic health record must have the ability to generate information on clinical quality measures and other measures reported under sections 4101, 4102, and 4201 of the HITECH Act.

(f) The electronic health record system must be connected to a state-certified health information organization either directly or through a connection facilitated by a ~~state-certified~~ health data intermediary as defined in section 62J.498.

(g) A health care provider who is a prescriber or dispenser of legend drugs must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 4. Minnesota Statutes 2020, section 62J.495, subdivision 4, is amended to read:

Subd. 4. **Coordination with national HIT activities.** (a) The commissioner, in consultation with the e-Health Advisory Committee, shall update the statewide implementation plan required under subdivision 2 and released June 2008, to be consistent with the updated federal ~~HIT Strategic Plan released by the Office of the National Coordinator in accordance with section 3001 of the HITECH Act. The statewide plan shall meet the requirements for a plan required under section 3013 of the HITECH Act~~ plans.

(b) The commissioner, in consultation with the e-Health Advisory Committee, shall work to ensure coordination between state, regional, and national efforts to support and accelerate efforts to effectively use health information technology to improve the quality

and coordination of health care and the continuity of patient care among health care providers, to reduce medical errors, to improve population health, to reduce health disparities, and to reduce chronic disease. The commissioner's coordination efforts shall include but not be limited to:

~~(1) assisting in the development and support of health information technology regional extension centers established under section 3012(c) of the HITECH Act to provide technical assistance and disseminate best practices;~~

~~(2) providing supplemental information to the best practices gathered by regional centers to ensure that the information is relayed in a meaningful way to the Minnesota health care community;~~

~~(3)~~ (1) providing financial and technical support to Minnesota health care providers to encourage implementation of admission, discharge and transfer alerts, and care summary document exchange transactions and to evaluate the impact of health information technology on cost and quality of care. Communications about available financial and technical support shall include clear information about the interoperable health record requirements in subdivision 1, including a separate statement in bold-face type clarifying the exceptions to those requirements;

~~(4)~~ (2) providing educational resources and technical assistance to health care providers and patients related to state and national privacy, security, and consent laws governing clinical health information, including the requirements in sections 144.291 to 144.298. In carrying out these activities, the commissioner's technical assistance does not constitute legal advice;

~~(5)~~ (3) assessing Minnesota's legal, financial, and regulatory framework for health information exchange, including the requirements in sections 144.291 to 144.298, and making recommendations for modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable; and

~~(6)~~ (4) seeking public input on both patient impact and costs associated with requirements related to patient consent for release of health records for the purposes of treatment, payment, and health care operations, as required in section 144.293, subdivision 2. The commissioner shall provide a report to the legislature on the findings of this public input process no later than February 1, 2017.

(c) The commissioner, in consultation with the e-Health Advisory Committee, shall monitor national activity related to health information technology and shall coordinate

statewide input on policy development. The commissioner shall coordinate statewide responses to proposed federal health information technology regulations in order to ensure that the needs of the Minnesota health care community are adequately and efficiently addressed in the proposed regulations. The commissioner's responses may include, but are not limited to:

(1) reviewing and evaluating any standard, implementation specification, or certification criteria proposed by the national HIT standards ~~committee~~ committees;

(2) reviewing and evaluating policy proposed by ~~the~~ national HIT policy ~~committee~~ committees relating to the implementation of a nationwide health information technology infrastructure; and

(3) ~~monitoring and responding to activity related to the development of quality measures and other measures as required by section 4101 of the HITECH Act. Any response related to quality measures shall consider and address the quality efforts required under chapter 62U; and~~

~~(4)~~ monitoring and responding to national activity related to privacy, security, and data stewardship of electronic health information and individually identifiable health information.

(d) To the extent that the state is either required or allowed to apply, or designate an entity to apply for or carry out activities and programs ~~under section 3013 of the HITECH Act~~, the commissioner of health, in consultation with the e-Health Advisory Committee and the commissioner of human services, shall be the lead applicant or sole designating authority. The commissioner shall make such designations consistent with the goals and objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

(e) The commissioner of human services shall apply for funding necessary to administer the incentive payments to providers authorized under title IV of the American Recovery and Reinvestment Act.

~~(f) The commissioner shall include in the report to the legislature information on the activities of this subdivision and provide recommendations on any relevant policy changes that should be considered in Minnesota.~~

Sec. 5. Minnesota Statutes 2020, section 62J.497, subdivision 1, is amended to read:

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

(b) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(d) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(e) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(f) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(g) "Electronic prescription drug program" means a program that provides for e-prescribing.

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

(i) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(j) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(k) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(l) "NCPDP Formulary and Benefits Standard" means the most recent version of the National Council for Prescription Drug Programs Formulary and Benefits Standard~~,~~ ~~Implementation Guide, Version 1, Release 0, October 2005~~ or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance.

(m) "NCPDP SCRIPT Standard" means the most recent version of the National Council for Prescription Drug Programs ~~Prescriber/Pharmacist Interface~~ SCRIPT Standard, ~~Implementation Guide Version 8, Release 1 (Version 8.1), October 2005,~~ or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. ~~Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.~~

(n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(o) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

(p) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(q) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Sec. 6. Minnesota Statutes 2020, section 62J.497, subdivision 3, is amended to read:

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. ~~The NCPDP SCRIPT Standard shall be used to conduct the following transactions:~~

~~(1) get message transaction;~~

~~(2) status response transaction;~~

~~(3) error response transaction;~~

~~(4) new prescription transaction;~~

~~(5) prescription change request transaction;~~

~~(6) prescription change response transaction;~~

~~(7) refill prescription request transaction;~~

~~(8) refill prescription response transaction;~~

~~(9) verification transaction;~~

~~(10) password change transaction;~~

~~(11) cancel prescription request transaction; and~~

~~(12) cancel prescription response transaction.~~

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

Sec. 7. Minnesota Statutes 2020, section 62J.498, is amended to read:

62J.498 HEALTH INFORMATION EXCHANGE.

Subdivision 1. **Definitions.** (a) The following definitions apply to sections 62J.498 to 62J.4982:

(b) "Clinical data repository" means a real time database that consolidates data from a variety of clinical sources to present a unified view of a single patient and is used by a ~~state-certified~~ health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include clinical data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

(c) "Clinical transaction" means any meaningful use transaction or other health information exchange transaction that is not covered by section 62J.536.

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

(e) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(f) "Health data intermediary" means an entity that provides the technical capabilities or related products and services to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This includes but is not limited to health information service providers (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries as defined in section 62J.495.

(g) "Health information exchange" means the electronic transmission of health-related information between organizations according to nationally recognized standards.

(h) "Health information exchange service provider" means a health data intermediary or health information organization.

(i) "Health information organization" means an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k), to improve coordination of patient care and the efficiency of health care delivery.

~~(j) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act as defined in section 62J.495.~~

~~(k)~~ (j) "Major participating entity" means:

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health information exchange service provider;

(2) a participating entity providing administrative, financial, or management services to the health information organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health information organization; and

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors or equivalent governing body of the health information organization.

~~(l)~~ (k) "Master patient index" means an electronic database that holds unique identifiers of patients registered at a care facility and is used by a ~~state-certified~~ health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

~~(m) "Meaningful use" means use of certified electronic health record technology to improve quality, safety, and efficiency and reduce health disparities; engage patients and families; improve care coordination and population and public health; and maintain privacy and security of patient health information as established by the Centers for Medicare and Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

~~(n) "Meaningful use transaction" means an electronic transaction that a health care provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

~~(o)~~ (l) "Participating entity" means any of the following persons, health care providers, companies, or other organizations with which a health information organization ~~or health data intermediary~~ has contracts or other agreements for the provision of health information exchange services:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

~~(p)~~ (m) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of clinical transactions.

~~(q) "State-certified health data intermediary" means a health data intermediary that has been issued a certificate of authority to operate in Minnesota.~~

~~(r)~~ (n) "State-certified health information organization" means a health information organization that has been issued a certificate of authority to operate in Minnesota.

Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from ~~health data intermediaries and~~ health information organizations for certificates of authority to operate in Minnesota;

(2) require information to be provided as needed from health information exchange service providers in order to meet requirements established under sections 62J.498 to 62J.4982;

~~(2)~~ (3) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

~~(3)~~ (4) respond to public complaints related to health information exchange services;

~~(4)~~ (5) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

~~(5)~~ (6) provide a biennial report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences; and

~~(6)~~ (7) other duties necessary to protect the public interest.

(b) As part of the application review process for certification under paragraph (a), prior to issuing a certificate of authority, the commissioner shall:

(1) make all portions of the application classified as public data available to the public for at least ten days while an application is under consideration. At the request of the commissioner, the applicant shall participate in a public hearing by presenting an overview of their application and responding to questions from interested parties; and

(2) consult with hospitals, physicians, and other providers prior to issuing a certificate of authority.

(c) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(d) The commissioner may disclose data classified as protected nonpublic or confidential under paragraph (c) if disclosing the data will protect the health or safety of patients.

(e) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

Sec. 8. Minnesota Statutes 2020, section 62J.4981, is amended to read:

62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.

Subdivision 1. **Authority to require organizations to apply.** The commissioner shall require ~~a health data intermediary or~~ a health information organization to apply for a certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is considered a health information exchange service provider whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

~~Subd. 2.~~ **~~Certificate of authority for health data intermediaries.~~** ~~(a) A health data intermediary must be certified by the state and comply with requirements established in this section.~~

~~(b) Notwithstanding any law to the contrary, any corporation organized to do so may apply to the commissioner for a certificate of authority to establish and operate as a health data intermediary in compliance with this section. No person shall establish or operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health data intermediary contract unless the organization has a certificate of authority or has an application under active consideration under this section.~~

~~(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:~~

~~(1) hold reciprocal agreements with at least one state-certified health information organization to access patient data, and for the transmission and receipt of clinical transactions. Reciprocal agreements must meet the requirements established in subdivision 5; and~~

~~(2) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability between state-certified health information organizations and state-certified health data intermediaries.~~

Subd. 3. **Certificate of authority for health information organizations.** (a) A health information organization must obtain a certificate of authority from the commissioner and demonstrate compliance with the criteria in paragraph (c).

(b) Notwithstanding any law to the contrary, an organization may apply for a certificate of authority to establish and operate a health information organization under this section. No person shall establish or operate a health information organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health information organization or health information contract unless the organization has a certificate of authority under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

(1) the entity is a legally established organization;

(2) appropriate insurance, including liability insurance, for the operation of the health information organization is in place and sufficient to protect the interest of the public and participating entities;

(3) strategic and operational plans address governance, technical infrastructure, legal and policy issues, finance, and business operations in regard to how the organization will expand to support providers in achieving health information exchange goals over time;

(4) the entity addresses the parameters to be used with participating entities and other health information exchange service providers for clinical transactions, compliance with Minnesota law, and interstate health information exchange trust agreements;

(5) the entity's board of directors or equivalent governing body is composed of members that broadly represent the health information organization's participating entities and consumers;

(6) the entity maintains a professional staff responsible to the board of directors or equivalent governing body with the capacity to ensure accountability to the organization's mission;

(7) the organization is compliant with national certification and accreditation programs designated by the commissioner;

(8) the entity maintains the capability to query for patient information based on national standards. The query capability may utilize a master patient index, clinical data repository, or record locator service as defined in section 144.291, subdivision 2, paragraph (j). The entity must be compliant with the requirements of section 144.293, subdivision 8, when conducting clinical transactions;

(9) the organization demonstrates interoperability with all other state-certified health information organizations using nationally recognized standards;

(10) the organization demonstrates compliance with all privacy and security requirements required by state and federal law; and

(11) the organization uses financial policies and procedures consistent with generally accepted accounting principles and has an independent audit of the organization's financials on an annual basis.

(d) Health information organizations that have obtained a certificate of authority must:

(1) meet the requirements established for connecting to the National eHealth Exchange;

(2) annually submit strategic and operational plans for review by the commissioner that address:

(i) progress in achieving objectives included in previously submitted strategic and operational plans across the following domains: business and technical operations, technical infrastructure, legal and policy issues, finance, and organizational governance;

(ii) plans for ensuring the necessary capacity to support clinical transactions;

(iii) approach for attaining financial sustainability, including public and private financing strategies, and rate structures;

(iv) rates of adoption, utilization, and transaction volume, and mechanisms to support health information exchange; and

(v) an explanation of methods employed to address the needs of community clinics, critical access hospitals, and free clinics in accessing health information exchange services;

(3) enter into reciprocal agreements with all other state-certified health information organizations ~~and state-certified health data intermediaries~~ to enable access to patient data, and for the transmission and receipt of clinical transactions. Reciprocal agreements must meet the requirements in subdivision 5;

(4) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability ~~between state-certified health information organizations and state-certified health data intermediaries~~; and

(5) comply with additional requirements for the certification or recertification of health information organizations that may be established by the commissioner.

Subd. 4. **Application for certificate of authority for health information ~~exchange service providers~~ organizations.** (a) Each application for a certificate of authority shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant. Each application shall include the following in addition to information described in the criteria in ~~subdivisions 2 and~~ subdivision 3:

(1) ~~for health information organizations only,~~ a copy of the basic organizational document, if any, of the applicant and of each major participating entity, such as the articles of incorporation, or other applicable documents, and all amendments to it;

(2) ~~for health information organizations only,~~ a list of the names, addresses, and official positions of the following:

(i) all members of the board of directors or equivalent governing body, and the principal officers and, if applicable, shareholders of the applicant organization; and

(ii) all members of the board of directors or equivalent governing body, and the principal officers of each major participating entity and, if applicable, each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

(3) ~~for health information organizations only,~~ the name and address of each participating entity and the agreed-upon duration of each contract or agreement if applicable;

(4) a copy of each standard agreement or contract intended to bind the participating entities and the health information ~~exchange service provider~~ organization. Contractual provisions shall be consistent with the purposes of this section, in regard to the services to be performed under the standard agreement or contract, the manner in which payment for

services is determined, the nature and extent of responsibilities to be retained by the health information organization, and contractual termination provisions;

(5) a statement generally describing the health information ~~exchange service provider~~ organization, its health information exchange contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide participants with comprehensive health information exchange services;

(6) a statement reasonably describing the geographic area or areas to be served and the type or types of participants to be served;

(7) a description of the complaint procedures to be used as required under this section;

(8) a description of the mechanism by which participating entities will have an opportunity to participate in matters of policy and operation;

(9) a copy of any pertinent agreements between the health information organization and insurers, including liability insurers, demonstrating coverage is in place;

(10) a copy of the conflict of interest policy that applies to all members of the board of directors or equivalent governing body and the principal officers of the health information organization; and

(11) other information as the commissioner may reasonably require to be provided.

(b) Within 45 days after the receipt of the application for a certificate of authority, the commissioner shall determine whether or not the application submitted meets the requirements for completion in paragraph (a), and notify the applicant of any further information required for the application to be processed.

(c) Within 90 days after the receipt of a complete application for a certificate of authority, the commissioner shall issue a certificate of authority to the applicant if the commissioner determines that the applicant meets the minimum criteria requirements of ~~subdivision 2 for health data intermediaries or~~ subdivision 3 ~~for health information organizations~~. If the commissioner determines that the applicant is not qualified, the commissioner shall notify the applicant and specify the reasons for disqualification.

(d) Upon being granted a certificate of authority to operate as a state-certified health information organization ~~or state-certified health data intermediary~~, the organization must operate in compliance with the provisions of this section. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority according to section 62J.4982.

Subd. 5. **Reciprocal agreements between health information ~~exchange entities~~ organizations.** (a) Reciprocal agreements between two health information organizations ~~or between a health information organization and a health data intermediary~~ must include a fair and equitable model for charges between the entities that:

(1) does not impede the secure transmission of clinical transactions;

(2) does not charge a fee for the exchange of ~~meaningful use~~ transactions transmitted according to nationally recognized standards where no additional value-added service is rendered to the sending or receiving health information organization ~~or health data intermediary~~ either directly or on behalf of the client;

(3) is consistent with fair market value and proportionately reflects the value-added services accessed as a result of the agreement; and

(4) prevents health care stakeholders from being charged multiple times for the same service.

(b) Reciprocal agreements must include comparable quality of service standards that ensure equitable levels of services.

(c) Reciprocal agreements are subject to review and approval by the commissioner.

(d) Nothing in this section precludes a state-certified health information organization ~~or state-certified health data intermediary~~ from entering into contractual agreements for the provision of value-added services ~~beyond meaningful use transactions~~.

Sec. 9. Minnesota Statutes 2020, section 62J.4982, is amended to read:

62J.4982 ENFORCEMENT AUTHORITY; COMPLIANCE.

Subdivision 1. **Penalties and enforcement.** (a) The commissioner may, for any violation of statute or rule applicable to a health information ~~exchange service provider~~ organization, levy an administrative penalty in an amount up to $25,000 for each violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of participating entities affected by the violation;

(2) the effect of the violation on participating entities' access to health information exchange services;

(3) if only one participating entity is affected, the effect of the violation on the patients of that entity;

(4) whether the violation is an isolated incident or part of a pattern of violations;

(5) the economic benefits derived by the health information organization ~~or a health data intermediary~~ by virtue of the violation;

(6) whether the violation hindered or facilitated an individual's ability to obtain health care;

(7) whether the violation was intentional;

(8) whether the violation was beyond the direct control of the health information ~~exchange service provider~~ organization;

(9) any history of prior compliance with the provisions of this section, including violations;

(10) whether and to what extent the health information ~~exchange service provider~~ organization attempted to correct previous violations;

(11) how the health information ~~exchange service provider~~ organization responded to technical assistance from the commissioner provided in the context of a compliance effort; and

(12) the financial condition of the health information ~~exchange service provider~~ organization including~~,~~ but not limited to~~,~~ whether the health information ~~exchange service provider~~ organization had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information ~~exchange service provider~~ organization to continue to deliver health information exchange services.

The commissioner shall give reasonable notice in writing to the health information ~~exchange service provider~~ organization of the intent to levy the penalty and the reasons for it. A health information ~~exchange service provider~~ organization may have 15 days within which to contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982, according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(b) If the commissioner has reason to believe that a violation of section 62J.4981 or 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved before commencing action under subdivision 2. The commissioner may notify the health information ~~exchange service provider~~ organization and the representatives, or other persons who appear to be involved in the suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives. The purpose of the conference is to attempt to learn the facts about the suspected violation and, if it appears that a violation

has occurred or is threatened, to find a way to correct or prevent it. The conference is not governed by any formal procedural requirements, and may be conducted as the commissioner considers appropriate.

(c) The commissioner may issue an order directing a health information ~~exchange service provider~~ organization or a representative of a health information ~~exchange service provider~~ organization to cease and desist from engaging in any act or practice in violation of sections 62J.4981 and 62J.4982.

(d) Within 20 days after service of the order to cease and desist, a health information ~~exchange service provider~~ organization may contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(e) In the event of noncompliance with a cease and desist order issued under this subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey County District Court.

Subd. 2. **Suspension or revocation of certificates of authority.** (a) The commissioner may suspend or revoke a certificate of authority issued to a ~~health data intermediary or~~ health information organization under section 62J.4981 if the commissioner finds that:

(1) the health information ~~exchange service provider~~ organization is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62J.4981, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the health information ~~exchange service provider~~ organization is unable to fulfill its obligations to furnish comprehensive health information exchange services as required under its health information exchange contract;

(3) the health information ~~exchange service provider~~ organization is no longer financially solvent or may not reasonably be expected to meet its obligations to participating entities;

(4) the health information ~~exchange service provider~~ organization has failed to implement the complaint system in a manner designed to reasonably resolve valid complaints;

(5) the health information ~~exchange service provider~~ organization, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misleading, deceptive, or unfair manner;

(6) the continued operation of the health information ~~exchange service provider~~ organization would be hazardous to its participating entities or the patients served by the participating entities; or

(7) the health information ~~exchange service provider~~ organization has otherwise failed to substantially comply with section 62J.4981 or with any other statute or administrative rule applicable to health information exchange service providers, or has submitted false information in any report required under sections 62J.498 to 62J.4982.

(b) A certificate of authority shall be suspended or revoked only after meeting the requirements of subdivision 3.

(c) If the certificate of authority of a health information ~~exchange service provider~~ organization is suspended, the health information ~~exchange service provider~~ organization shall not, during the period of suspension, enroll any additional participating entities, and shall not engage in any advertising or solicitation.

(d) If the certificate of authority of a health information ~~exchange service provider~~ organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may, by written order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the greatest practical opportunity to access continuing health information exchange services.

Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a) When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, the commissioner shall notify the health information ~~exchange service provider~~ organization in writing stating the grounds for denial, suspension, or revocation and setting a time within 20 days for a hearing on the matter.

(b) After a hearing before the commissioner at which the health information ~~exchange service provider~~ organization may respond to the grounds for denial, suspension, or revocation, or upon the failure of the health information exchange service provider to appear at the hearing, the commissioner shall take action as deemed necessary and shall issue written findings and mail them to the health information ~~exchange service provider~~ organization.

(c) If suspension, revocation, or administrative penalty is proposed according to this section, the commissioner must deliver, or send by certified mail with return receipt requested, to the health information ~~exchange service provider~~ organization written notice of the commissioner's intent to impose a penalty. This notice of proposed determination must include:

(1) a reference to the statutory basis for the penalty;

(2) a description of the findings of fact regarding the violations with respect to which the penalty is proposed;

(3) the nature and amount of the proposed penalty;

(4) any circumstances described in subdivision 1, paragraph (a), that were considered in determining the amount of the proposed penalty;

(5) instructions for responding to the notice, including a statement of the health information ~~exchange service provider's~~ organization's right to a contested case proceeding and a statement that failure to request a contested case proceeding within 30 calendar days permits the imposition of the proposed penalty; and

(6) the address to which the contested case proceeding request must be sent.

Subd. 4. **Coordination.** The commissioner shall, to the extent possible, seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the certification and recertification of health information ~~exchange service providers~~ organizations when implementing sections 62J.498 to 62J.4982.

Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every health information ~~exchange service provider~~ organization subject to sections 62J.4981 and 62J.4982 as follows:

(1) filing an application for certificate of authority to operate as a health information organization, $7,000; and

(2) ~~filing an application for certificate of authority to operate as a health data intermediary, $7,000;~~

~~(3)~~ annual health information organization certificate fee, $7,000~~; and~~.

~~(4) annual health data intermediary certificate fee, $7,000.~~

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

(c) Administrative monetary penalties imposed under this subdivision shall be credited to an account in the special revenue fund and are appropriated to the commissioner for the purposes of sections 62J.498 to 62J.4982.

Sec. 10. Minnesota Statutes 2020, section 62J.63, subdivision 1, is amended to read:

Subdivision 1. **~~Establishment; administration~~ Support for state health care purchasing and performance measurement.** The commissioner of health shall ~~establish and administer the Center for Health Care Purchasing Improvement as an administrative unit within the Department of Health. The Center for Health Care Purchasing Improvement shall~~ support the state in its efforts to be a more prudent and efficient purchaser of quality health care services~~. The center shall~~, aid the state in developing and using more common strategies and approaches for health care performance measurement and health care purchasing~~. The common strategies and approaches shall~~, promote greater transparency of health care costs and quality~~,~~ and greater accountability for health care results and improvement~~. The center shall also~~, and identify barriers to more efficient, effective, quality health care and options for overcoming the barriers.

Sec. 11. Minnesota Statutes 2020, section 62J.63, subdivision 2, is amended to read:

Subd. 2. **~~Staffing;~~ Duties; scope.** ~~(a)~~ The commissioner of health may ~~appoint a director, and up to three additional senior-level staff or codirectors, and other staff as needed who are under the direction of the commissioner. The staff of the center are in the unclassified service.~~:

~~(b) With the authorization of the commissioner of health, and in consultation or interagency agreement with the appropriate commissioners of state agencies, the director, or codirectors, may:~~

~~(1) initiate projects to develop plan designs for state health care purchasing;~~

~~(2)~~ (1) require reports or surveys to evaluate the performance of current health care purchasing or administrative simplification strategies;

~~(3)~~ (2) calculate fiscal impacts, including net savings and return on investment, of health care purchasing strategies and initiatives;

~~(4) conduct policy audits of state programs to measure conformity to state statute or other purchasing initiatives or objectives;~~

~~(5)~~ (3) support the Administrative Uniformity Committee under ~~section~~ sections 62J.50 and 62J.536 and other relevant groups or activities to advance agreement on health care administrative process streamlining;

~~(6) consult with the Health Economics Unit of the Department of Health regarding reports and assessments of the health care marketplace;~~

~~(7) consult with the Department of Commerce regarding health care regulatory issues and legislative initiatives;~~

~~(8) work with appropriate Department of Human Services staff and the Centers for Medicare and Medicaid Services to address federal requirements and conformity issues for health care purchasing;~~

~~(9) assist the Minnesota Comprehensive Health Association in health care purchasing strategies;~~

~~(10) convene medical directors of agencies engaged in health care purchasing for advice, collaboration, and exploring possible synergies;~~

~~(11)~~ (4) contact and participate with other relevant health care task forces, study activities, and similar efforts with regard to health care performance measurement and performance-based purchasing; and

~~(12)~~ (5) assist in seeking external funding through appropriate grants or other funding opportunities and may administer grants and externally funded projects.

Sec. 12. Minnesota Statutes 2020, section 62U.04, subdivision 4, is amended to read:

Subd. 4. **Encounter data.** (a) ~~Beginning July 1, 2009, and every six months thereafter,~~ All health plan companies and third-party administrators shall submit encounter data on a monthly basis to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:

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

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

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

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

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the data classifications in this paragraph, data on providers collected under this subdivision may be released or published as authorized in subdivision 11. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner or the commissioner's designee shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

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

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

Sec. 13. Minnesota Statutes 2020, section 62U.04, subdivision 5, is amended to read:

Subd. 5. **Pricing data.** (a) Beginning July 1, 2009, and annually on January 1 thereafter, all health plan companies and third-party administrators shall submit data on their contracted prices with health care providers to a private entity designated by the commissioner of health for the purposes of performing the analyses required under this subdivision. The data shall be submitted in the form and manner specified by the commissioner of health.

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

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

(c) Data collected under this subdivision are nonpublic data as defined in section 13.02. Notwithstanding the data classification in this paragraph, data collected under this subdivision may be released or published as authorized in subdivision 11. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

Sec. 14. Minnesota Statutes 2020, section 62U.04, subdivision 11, is amended to read:

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

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

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

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

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

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

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

(ii) not identify individual patients, or payers~~, or providers~~ but that may identify the rendering or billing hospital, clinic, or medical practice;

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

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

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

(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) ~~so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned~~. The data published under this paragraph may identify hospitals, clinics, and medical practices so long as no individual health professionals are identified and the commissioner finds the data to be accurate, valid, and suitable for publication for such use.

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

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

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

Sec. 15. Minnesota Statutes 2020, section 103H.201, subdivision 1, is amended to read:

Subdivision 1. **Procedure.** (a) If groundwater quality monitoring results show that there is a degradation of groundwater, the commissioner of health may promulgate health risk limits under subdivision 2 for substances degrading the groundwater.

(b) Health risk limits shall be determined by two methods depending on their toxicological end point.

(c) For systemic toxicants that are not carcinogens, the adopted health risk limits shall be derived using United States Environmental Protection Agency risk assessment methods using a reference dose, a drinking water equivalent, and a relative source contribution factor.

(d) For toxicants that are known or probable carcinogens, the adopted health risk limits shall be derived from a quantitative estimate of the chemical's carcinogenic potency published

by the United States Environmental Protection Agency ~~and~~ or determined by the commissioner to have undergone thorough scientific review.

Sec. 16. **[144.066] DISTRIBUTION OF COVID-19 VACCINES.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section and sections 144.067 to 144.069.

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

(c) "COVID-19 vaccine" means a vaccine against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

(d) "Department" means the Department of Health.

(e) "Disproportionately impacted community" means a community or population that has been disproportionately and negatively impacted by the COVID-19 pandemic.

(f) "Local health department" has the meaning given in section 145A.02, subdivision 8b.

(g) "Mobile vaccination vehicle" means a vehicle-mounted unit that is either motorized or trailered, that is readily movable without disassembling, and at which vaccines are provided in more than one geographic location.

Subd. 2. **Distribution.** The commissioner shall establish and maintain partnerships or agreements with local health departments; local health care providers, including community health centers and primary care providers; and local pharmacies to administer COVID-19 vaccines throughout the state. COVID-19 vaccines may also be administered via mobile vaccination vehicles authorized under section 144.068.

Subd. 3. **Second dose or booster.** For all COVID-19 vaccines for which a second dose or booster is required, during the first vaccine appointment the registered vaccine provider should be directed by the department during the vaccine provider registration process to assist vaccine recipients with scheduling an appointment for the second dose or booster. This assistance may be provided during the observation period following vaccine administration.

Subd. 4. **Nondiscrimination.** Nothing in sections 144.066 to 144.069 shall be construed to allow or require the denial of any benefit or opportunity on the basis of race, color, creed, marital status, status with regard to public assistance, disability, genetic information, sexual orientation, age, religion, national origin, sex, or membership in a local human rights commission.

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

Sec. 17. **[144.067] EQUITABLE COVID-19 VACCINE DISTRIBUTION.**

Subdivision 1. **COVID-19 vaccination equity and outreach.** The commissioner shall establish positions to continue the department's COVID-19 vaccination equity and outreach activities and to plan and implement actions and programs to overcome disparities in COVID-19 vaccination rates that are rooted in historic and current racism; biases based on ethnicity, income, primary language, immigration status, or disability; geography; or transportation access, language access, or Internet access. This work shall be managed by a director who shall serve in a leadership role in the department's COVID-19 response.

Subd. 2. **Vaccine education and outreach campaign; direct delivery of information.** (a) The commissioner shall administer a COVID-19 vaccine education and outreach campaign that engages in direct delivery of information to members of disproportionately impacted communities. In this campaign, the commissioner shall contract with community-based organizations including community faith-based organizations, tribal governments, local health departments, and local health care providers, including community health centers and primary care providers, to deliver the following information in a culturally relevant and linguistically appropriate manner:

(1) medically and scientifically accurate information on the safety, efficacy, science, and benefits of vaccines generally and COVID-19 vaccines in particular;

(2) information on how members of disproportionately impacted communities may obtain a COVID-19 vaccine including, if applicable, obtaining a vaccine from a mobile vaccination vehicle; and

(3) measures to prevent transmission of COVID-19, including adequate indoor ventilation, wearing face coverings, and physical distancing from individuals outside the household.

(b) This information must be delivered directly by methods that include phone calls, text messages, physically distanced door-to-door and street canvassing, and digital event-based communication involving live and interactive messengers. For purposes of this subdivision, direct delivery shall not include delivery by television, radio, newspaper, or other forms of mass media.

Subd. 3. **Vaccine education and outreach campaign; mass media.** The commissioner shall administer a mass media campaign to provide COVID-19 vaccine education and outreach to members of disproportionately impacted communities. In this campaign, the commissioner shall contract with media vendors to provide the following information to

members of disproportionately impacted communities in a manner that is culturally relevant and linguistically appropriate:

(1) medically and scientifically accurate information on the safety, efficacy, science, and benefits of COVID-19 vaccines; and

(2) information on how members of disproportionately impacted communities may obtain a COVID-19 vaccine.

Subd. 4. **Community assistance.** The commissioner shall administer a program to help members of disproportionately impacted communities arrange for and prepare to obtain a COVID-19 vaccine and to support transportation-limited members of these communities with transportation to vaccination appointments or otherwise arrange for vaccine providers to reach members of these communities.

Subd. 5. **Equitable distribution of COVID-19 vaccines.** The commissioner shall establish a set of metrics to measure the equitable distribution of COVID-19 vaccines in the state, and shall set and periodically update goals for COVID-19 vaccine distribution in the state that are focused on equity.

Subd. 6. **Expiration of programs.** The vaccine education and outreach programs in subdivisions 2 and 3 and the community assistance program in subdivision 4 shall operate until a sufficient percentage of individuals in each county or census tract have received the full series of COVID-19 vaccines to protect individuals in each county or census tract from COVID-19.

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

Sec. 18. **[144.068] MOBILE VACCINATION PROGRAM.**

Subdivision 1. **Administration.** The commissioner, in partnership with local health departments and the regional health care coalitions, shall administer a mobile vaccination program in which mobile vaccination vehicles are deployed to communities around the state to provide COVID-19 vaccines to individuals. The commissioner shall deploy mobile vaccination vehicles to communities to improve access to vaccines based on factors that include but are not limited to vulnerability, likelihood of exposure, limits to transportation access, rate of vaccine uptake, and limited access to vaccines or barriers to obtaining vaccines.

Subd. 2. **Eligibility.** Notwithstanding the phases and priorities of the state's COVID-19 allocation and prioritization plan or guidance, all individuals in a community to which a mobile vaccination vehicle is deployed shall be eligible to receive COVID-19 vaccines from the vehicle.

Subd. 3. **Staffing.** Each mobile vaccination vehicle must be staffed in accordance with Centers for Disease Control and Prevention guidelines and may be staffed with additional support staff based on needs determined by local request. Additional support staff may include but are not limited to community partners and translators.

Subd. 4. **Second doses.** For vaccine recipients who receive a first dose of a COVID-19 vaccine from a mobile vaccination vehicle, vehicle staff shall provide assistance in scheduling an appointment with a mobile vaccination vehicle or with another vaccine provider for any needed second dose or booster. The commissioner shall, to the extent possible, deploy mobile vaccination vehicles in a manner that allows vaccine recipients to receive second doses or boosters from a mobile vaccination vehicle.

Subd. 5. **Expiration.** The commissioner shall administer the mobile vaccination vehicle program until a sufficient percentage of individuals in each county or census tract have received the full series of COVID-19 vaccines to protect individuals in each county or census tract from the spread of COVID-19.

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

Sec. 19. **[144.069] COVID-19 VACCINATION PLAN AND DATA; REPORTS.**

Subdivision 1. **COVID-19 vaccination plan; implementation protocols.** The commissioner shall:

(1) publish the set of metrics and goals for equitable COVID-19 vaccine distribution established by the commissioner under section 144.067, subdivision 5; and

(2) publish implementation protocols to address the disparities in COVID-19 vaccination rates in certain communities and ensure that members of disproportionately impacted communities are given adequate access to COVID-19 vaccines.

Subd. 2. **Data on COVID-19 vaccines.** On at least a weekly basis, the commissioner shall publish on the department website:

(1) data measuring compliance with the set of metrics and goals for equitable COVID-19 vaccine distribution established by the commissioner under section 144.067, subdivision 5; and

(2) summary data on individuals who have received one or two doses of a COVID-19 vaccine, broken out by race, gender, ethnicity, age within an age range, and zip code.

Subd. 3. **Quarterly reports.** On a quarterly basis while funds are available, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over finance, ways and means, and health care:

(1) funds distributed to local health departments for COVID-19 activities and the sources of the funds; and

(2) funds expended to implement sections 144.066 to 144.069.

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

Sec. 20. Minnesota Statutes 2020, section 144.0724, subdivision 1, is amended to read:

Subdivision 1. **Resident reimbursement case mix classifications.** The commissioner of health shall establish resident reimbursement case mix classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under this section and according to section 256R.17.

Sec. 21. Minnesota Statutes 2020, section 144.0724, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given.

(a) "Assessment reference date" or "ARD" means the specific end point for look-back periods in the MDS assessment process. This look-back period is also called the observation or assessment period.

(b) "Case mix index" means the weighting factors assigned to the RUG-IV classifications.

(c) "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment, and functional status elements, that include common definitions and coding categories specified by the Centers for Medicare and Medicaid Services and designated by the ~~Minnesota~~ Department of Health.

(e) "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the Office of Ombudsman for Long-Term Care whose assistance has been requested, or any other individual designated by the resident.

(f) "Resource utilization groups" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by the facility's Minimum Data Set.

(g) "Activities of daily living" ~~means grooming,~~ includes personal hygiene, dressing, bathing, transferring, bed mobility, ~~positioning,~~ locomotion, eating, and toileting.

(h) "Nursing facility level of care determination" means the assessment process that results in a determination of a resident's or prospective resident's need for nursing facility level of care as established in subdivision 11 for purposes of medical assistance payment of long-term care services for:

(1) nursing facility services under section 256B.434 or chapter 256R;

(2) elderly waiver services under chapter 256S;

(3) CADI and BI waiver services under section 256B.49; and

(4) state payment of alternative care services under section 256B.0913.

Sec. 22. Minnesota Statutes 2020, section 144.0724, subdivision 3a, is amended to read:

Subd. 3a. **Resident reimbursement case mix classifications beginning January 1, 2012.** (a) Beginning January 1, 2012, resident reimbursement case mix classifications shall be based on the Minimum Data Set, version 3.0 assessment instrument, or its successor version mandated by the Centers for Medicare and Medicaid Services that nursing facilities are required to complete for all residents. The commissioner of health shall establish resident classifications according to the RUG-IV, 48 group, resource utilization groups. Resident classification must be established based on the individual items on the Minimum Data Set, which must be completed according to the Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 or its successor issued by the Centers for Medicare and Medicaid Services.

(b) Each resident must be classified based on the information from the Minimum Data Set according to general categories ~~as defined in the Case Mix Classification Manual for Nursing Facilities~~ issued by the Minnesota Department of Health.

Sec. 23. Minnesota Statutes 2020, section 144.0724, subdivision 5, is amended to read:

Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an admission assessment for all residents who stay in the facility 14 days or less~~.~~, unless the resident is admitted and discharged from the facility on the same day, in which case the

admission assessment is not required. When an admission assessment is not submitted, the case mix classification shall be the rate with a case mix index of 1.0.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make this election annually.

(c) Nursing facilities must elect one of the options described in paragraphs (a) and (b) by reporting to the commissioner of health, as prescribed by the commissioner. The election is effective on July 1 each year.

Sec. 24. Minnesota Statutes 2020, section 144.0724, subdivision 7, is amended to read:

Subd. 7. **Notice of resident reimbursement case mix classification.** (a) The commissioner of health shall provide to a nursing facility a notice for each resident of the ~~reimbursement~~ classification established under subdivision 1. The notice must inform the resident of the case mix classification ~~that was~~ assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification and the address and telephone number of the Office of Ombudsman for Long-Term Care. The commissioner must transmit the notice of resident classification by electronic means to the nursing facility. ~~A~~ The nursing facility is responsible for the distribution of the notice to each resident~~, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident~~ or the resident's representative. This notice must be distributed within three ~~working~~ business days after the facility's receipt ~~of the electronic file of notice of case mix classifications from the commissioner of health~~.

(b) If a facility submits a ~~modification to the most recent assessment used to establish a case mix classification conducted under subdivision 3 that results~~ modifying assessment resulting in a change in the case mix classification, the facility ~~shall give~~ must provide a written notice to the resident or the resident's representative ~~about~~ regarding the item or items that ~~was~~ were modified and the reason for the ~~modification~~ modifications. The notice ~~of modified assessment may~~ must be provided ~~at the same time that the resident or resident's representative is provided the resident's modified notice of classification~~ within three business days after distribution of the resident classification notice.

Sec. 25. Minnesota Statutes 2020, section 144.0724, subdivision 8, is amended to read:

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement case mix classification and any item or items changed during the audit process. The request for reconsideration must be submitted in writing to the commissioner ~~within 30 days of the day the resident or the resident's representative receives the resident classification notice~~ of health.

(b) For reconsideration requests initiated by the resident or the resident's representative:

(1) The resident or the resident's representative must submit in writing a reconsideration request to the facility administrator within 30 days of receipt of the resident classification notice. The written request ~~for reconsideration~~ must include the ~~name of the resident, the name and address of the facility in which the resident resides, the~~ reasons for the reconsideration~~, and documentation supporting the~~ request. ~~The documentation accompanying the reconsideration request is limited to a copy of the MDS that determined the classification and other documents that would support or change the MDS findings.~~

(2) Within three business days of receiving the reconsideration request, the nursing facility must submit to the commissioner of health a completed reconsideration request form, a copy of the resident's or resident's representative's written request, and all supporting documentation used to complete the assessment being considered. If the facility fails to provide the required information, the reconsideration will be completed with the information submitted and the facility cannot make further reconsideration requests on this classification.

~~(b)~~ (3) Upon written request and within three business days, the nursing facility must give the resident or the resident's representative a copy of the assessment ~~form~~ being reconsidered and ~~the other~~ all supporting documentation ~~that was given to the commissioner of health~~ used to ~~support~~ complete the assessment ~~findings~~. ~~The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information.~~ Notwithstanding any law to the contrary, the facility may not charge a fee for providing copies of the requested documentation. If a facility fails to provide the ~~material~~ required documents within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information, and

~~that~~ as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) ~~in addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii)~~ For reconsideration requests initiated by the facility:

(1) The facility is required to inform the resident or the resident's representative in writing that a reconsideration of the resident's case mix classification is being requested. The notice must inform the resident or the resident's representative:

(i) of the date and reason for the reconsideration request;

(ii) of the potential for a classification and subsequent rate change;

(iii) of the extent of the potential rate change;

(iv) that copies of the request and supporting documentation are available for review; and

(v) that the resident or the resident's representative has the right to request a reconsideration.

(2) Within 30 days of receipt of the audit exit report or resident classification notice, the facility must submit to the commissioner of health a completed reconsideration request form, all supporting documentation used to complete the assessment being reconsidered, and a copy of ~~a~~ the notice ~~sent to~~ informing the resident or ~~to~~ the resident's representative~~.~~ ~~This notice must inform the resident or the resident's representative~~ that a reconsideration of the resident's classification is being requested~~, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration~~.

(3) If the facility fails to provide the required information ~~listed in item (iii) with the reconsideration request, the commissioner may request that the facility provide the information within 14 calendar days.~~, the reconsideration request ~~must~~ may be denied ~~if the information is then not provided,~~ and the facility may not make further reconsideration requests on ~~that specific reimbursement~~ this classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the assessment that determined the classification and upon the information provided to the commissioner of health under paragraphs (a) ~~and (b)~~ to (c). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 ~~working~~ business days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect characteristics of the resident at the time of the assessment. ~~The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made.~~ The commissioner must transmit the reconsideration classification notice by electronic means to the nursing facility. The nursing facility is responsible for the distribution of the notice to the resident or the resident's representative. The notice must be distributed by the nursing facility within three business days after receipt. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The ~~resident~~ case mix classification established by the commissioner shall be the classification ~~that~~ which applies to the resident while the request for reconsideration is pending. If a request for reconsideration applies to an assessment used to determine nursing facility level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing facility level of care while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Sec. 26. Minnesota Statutes 2020, section 144.0724, subdivision 9, is amended to read:

Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident assessments performed under section 256R.17 through any of the following: desk audits; on-site review of residents and their records; and interviews with staff, residents, or residents' families. The commissioner shall reclassify a resident if the commissioner determines that the resident was incorrectly classified.

(b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

(c) A facility must grant the commissioner access to examine the medical records relating to the resident assessments selected for audit under this subdivision. The commissioner may also observe and speak to facility staff and residents.

(d) The commissioner shall consider documentation under the time frames for coding items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment Instrument User's Manual published by the Centers for Medicare and Medicaid Services.

(e) The commissioner shall develop an audit selection procedure that includes the following factors:

(1) Each facility shall be audited annually. If a facility has two successive audits in which the percentage of change is five percent or less and the facility has not been the subject of a special audit in the past 36 months, the facility may be audited biannually. A stratified sample of 15 percent, with a minimum of ten assessments, of the most current assessments shall be selected for audit. If more than 20 percent of the RUG-IV classifications are changed as a result of the audit, the audit shall be expanded to a second 15 percent sample, with a minimum of ten assessments. If the total change between the first and second samples is 35 percent or greater, the commissioner may expand the audit to all of the remaining assessments.

(2) If a facility qualifies for an expanded audit, the commissioner may audit the facility again within six months. If a facility has two expanded audits within a 24-month period, that facility will be audited at least every six months for the next 18 months.

(3) The commissioner may conduct special audits if the commissioner determines that circumstances exist that could alter or affect the validity of case mix classifications of residents. These circumstances include, but are not limited to, the following:

(i) frequent changes in the administration or management of the facility;

(ii) an unusually high percentage of residents in a specific case mix classification;

(iii) a high frequency in the number of reconsideration requests received from a facility;

(iv) frequent adjustments of case mix classifications as the result of reconsiderations or audits;

(v) a criminal indictment alleging provider fraud;

(vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

(vii) an atypical pattern of scoring minimum data set items;

(viii) nonsubmission of assessments;

(ix) late submission of assessments; or

(x) a previous history of audit changes of 35 percent or greater.

(f) ~~Within 15 working days of completing the audit process, the commissioner shall make available electronically the results of the audit to the facility. If the results of the audit reflect a change in the resident's case mix classification, a case mix classification notice will be made available electronically to the facility, using the procedure in subdivision 7, paragraph (a). The notice must contain the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility of their right to review the commissioner's documents supporting the classification and to request a reconsideration of the classification. This notice must also include the address and telephone number of the Office of Ombudsman for Long-Term Care.~~ If the audit results in a case mix classification change, the commissioner must transmit the audit classification notice by electronic means to the nursing facility within 15 business days of completing an audit. The nursing facility is responsible for distribution of the notice to each resident or the resident's representative. This notice must be distributed by the nursing facility within three business days after receipt. The notice must inform the resident of the case mix classification assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, the opportunity to request a reconsideration of the classification, and the address and telephone number of the Office of Ombudsman for Long-Term Care.

Sec. 27. Minnesota Statutes 2020, section 144.0724, subdivision 12, is amended to read:

Subd. 12. **Appeal of nursing facility level of care determination.** (a) A resident or prospective resident whose level of care determination results in a denial of long-term care services can appeal the determination as outlined in section 256B.0911, subdivision 3a, paragraph (h), clause (9).

(b) The commissioner of human services shall ensure that notice of changes in eligibility due to a nursing facility level of care determination is provided to each affected recipient or the recipient's guardian at least 30 days before the effective date of the change. The notice shall include the following information:

(1) how to obtain further information on the changes;

(2) how to receive assistance in obtaining other services;

(3) a list of community resources; and

(4) appeal rights.

~~A recipient who meets the criteria in section 256B.0922, subdivision 2, paragraph (a), clauses (1) and (2), may request continued services pending appeal within the time period allowed~~

~~to request an appeal under section 256.045, subdivision 3, paragraph (i). This paragraph is in effect for appeals filed between January 1, 2015, and December 31, 2016.~~

Sec. 28. Minnesota Statutes 2020, section 144.1205, subdivision 2, is amended to read:

Subd. 2. **Initial and annual fee.** (a) A licensee must pay an initial fee that is equivalent to the annual fee upon issuance of the initial license.

(b) A licensee must pay an annual fee at least 60 days before the anniversary date of the issuance of the license. The annual fee is as follows:

TYPE	~~ANNUAL~~ LICENSE FEE
	~~$19,920~~
Academic broad scope - type A, B, or C	$25,896
~~Academic broad scope - type B~~	~~19,920~~
~~Academic broad scope - type C~~	~~19,920~~
Academic broad scope - type A, B, or C (4-8 locations)	$31,075
Academic broad scope - type A, B, or C (9 or more locations)	$36,254
	~~19,920~~
Medical broad scope - type A	$25,896
Medical broad scope- type A (4-8 locations)	$31,075
Medical broad scope- type A (9 or more locations)	$36,254
~~Medical institution - diagnostic and therapeutic~~	~~3,680~~
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$4,784
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (4-8 locations)	$5,740
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (9 or more locations)	$6,697
~~Medical institution - diagnostic (no written directives)~~	~~3,680~~
~~Medical private practice - diagnostic and therapeutic~~	~~3,680~~
~~Medical private practice - diagnostic (no written directives)~~	~~3,680~~
~~Eye applicators~~	~~3,680~~
~~Nuclear medical vans~~	~~3,680~~
~~High dose rate afterloader~~	~~3,680~~
~~Mobile high dose rate afterloader~~	~~3,680~~
~~Medical therapy - other emerging technology~~	~~3,680~~
	~~8,960~~
Teletherapy	$11,648

		~~8,960~~
	Gamma knife	$11,648
	Veterinary medicine	~~2,000~~ $2,600
	In vitro testing lab	~~2,000~~ $2,600
		~~8,800~~
	Nuclear pharmacy	$11,440
	Nuclear pharmacy (5 or more locations)	$13,728
	Radiopharmaceutical distribution (10 CFR 32.72)	~~3,840~~ $4,992
	Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~8,800~~ $11,440
	Radiopharmaceutical processing and distribution (10 CFR 32.72) (5 or more locations)	$13,728
	Medical sealed sources - distribution (10 CFR 32.74)	~~3,840~~ $4,992
	Medical sealed sources - processing and distribution (10 CFR 32.74)	~~8,800~~ $11,440
	Medical sealed sources - processing and distribution (10 CFR 32.74) (5 or more locations)	$13,728
	Well logging - sealed sources	~~3,760~~ $4,888
	Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~2,000~~ $2,600
	~~Measuring systems - portable gauge~~	~~2,000~~
	Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (4-8 locations)	$3,120
	Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (9 or more locations)	$3,640
	X-ray fluorescent analyzer	~~1,520~~ $1,976
	~~Measuring systems - gas chromatograph~~	~~2,000~~
	~~Measuring systems - other~~	~~2,000~~
	~~Broad scope~~ Manufacturing and distribution - type A broad scope	~~19,920~~ $25,896
	Manufacturing and distribution - type A broad scope (4-8 locations)	$31,075
	Manufacturing and distribution - type A broad scope (9 or more locations)	$36,254
	~~Broad scope~~ Manufacturing and distribution - type B or C broad scope	~~17,600~~ $22,880
	~~Broad scope Manufacturing and distribution - type C~~	~~17,600~~
	Manufacturing and distribution - type B or C broad scope (4-8 locations)	$27,456
	Manufacturing and distribution - type B or C broad scope (9 or more locations)	$32,032
	Manufacturing and distribution - other	~~5,280~~ $6,864
	Manufacturing and distribution - other (4-8 locations)	$8,236

Manufacturing and distribution - other (9 or more locations)	$9,609
	~~18,640~~
Nuclear laundry	$24,232
Decontamination services	~~4,960~~ $6,448
Leak test services only	~~2,000~~ $2,600
Instrument calibration service only~~, less than 100 curies~~	~~2,000~~ $2,600
~~Instrument calibration service only, 100 curies or more~~	~~2,000~~
Service, maintenance, installation, source changes, etc.	~~4,960~~ $6,448
Waste disposal service, prepackaged only	~~6,000~~ $7,800
	~~8,320~~
Waste disposal	$10,816
Distribution - general licensed devices (sealed sources)	~~1,760~~ $2,288
Distribution - general licensed material (unsealed sources)	~~1,120~~ $1,456
	~~9,840~~
Industrial radiography - fixed or temporary location	$12,792
~~Industrial radiography - temporary job sites~~	~~9,840~~
Industrial radiography - fixed or temporary location (5 or more locations)	$16,629
Irradiators, self-shielding~~, less than 10,000 curies~~	~~2,880~~ $3,744
Irradiators, other, less than 10,000 curies	~~5,360~~ $6,968
~~Irradiators, self-shielding, 10,000 curies or more~~	~~2,880~~
	~~9,520~~
Research and development - type A, B, or C broad scope	$12,376
~~Research and development - type B broad scope~~	~~9,520~~
~~Research and development - type C broad scope~~	~~9,520~~
Research and development - type A, B, or C broad scope (4-8 locations)	$14,851
Research and development - type A, B, or C broad scope (9 or more locations)	$17,326
Research and development - other	~~4,480~~ $5,824
Storage - no operations	~~2,000~~ $2,600
Source material - shielding	~~584~~ $759
Special nuclear material plutonium - neutron source in device	~~3,680~~ $4,784
Pacemaker by-product and/or special nuclear material - medical (institution)	~~3,680~~ $4,784
Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~5,280~~ $6,864
Accelerator-produced radioactive material	~~3,840~~ $4,992
Nonprofit educational institutions	~~300~~ $500
~~General license registration~~	~~150~~

Sec. 29. Minnesota Statutes 2020, section 144.1205, subdivision 4, is amended to read:

Subd. 4. **Initial and renewal application fee.** A licensee must pay an initial and a renewal application fee ~~as follows:~~ according to this subdivision.

TYPE	APPLICATION FEE
	~~$ 5,920~~
Academic broad scope - type A, B, or C	$6,808
~~Academic broad scope - type B~~	~~5,920~~
~~Academic broad scope - type C~~	~~5,920~~
Medical broad scope - type A	~~3,920~~ $4,508
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$1,748
~~Medical institution - diagnostic and therapeutic~~	~~1,520~~
~~Medical institution - diagnostic (no written directives)~~	~~1,520~~
~~Medical private practice - diagnostic and therapeutic~~	~~1,520~~
~~Medical private practice - diagnostic (no written directives)~~	~~1,520~~
~~Eye applicators~~	~~1,520~~
~~Nuclear medical vans~~	~~1,520~~
~~High dose rate afterloader~~	~~1,520~~
~~Mobile high dose rate afterloader~~	~~1,520~~
~~Medical therapy - other emerging technology~~	~~1,520~~
Teletherapy	~~5,520~~ $6,348
Gamma knife	~~5,520~~ $6,348
Veterinary medicine	~~960~~ $1,104
In vitro testing lab	~~960~~ $1,104
Nuclear pharmacy	~~4,880~~ $5,612
Radiopharmaceutical distribution (10 CFR 32.72)	~~2,160~~ $2,484
Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~4,880~~ $5,612
Medical sealed sources - distribution (10 CFR 32.74)	~~2,160~~ $2,484
Medical sealed sources - processing and distribution (10 CFR 32.74)	~~4,880~~ $5,612
Well logging - sealed sources	~~1,600~~ $1,840
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~960~~ $1,104
~~Measuring systems - portable gauge~~	~~960~~
X-ray fluorescent analyzer	~~584~~ $671
~~Measuring systems - gas chromatograph~~	~~960~~
~~Measuring systems - other~~	~~960~~

~~Broad scope~~ Manufacturing and distribution - type A, B, and C broad scope	~~5,920~~ $6,854
~~Broad scope manufacturing and distribution - type B~~	~~5,920~~
~~Broad scope manufacturing and distribution - type C~~	~~5,920~~
Manufacturing and distribution - other	~~2,320~~ $2,668
	~~10,080~~
Nuclear laundry	$11,592
Decontamination services	~~2,640~~ $3,036
Leak test services only	~~960~~ $1,104
Instrument calibration service only~~, less than 100 curies~~	~~960~~ $1,104
~~Instrument calibration service only, 100 curies or more~~	~~960~~
Service, maintenance, installation, source changes, etc.	~~2,640~~ $3,036
Waste disposal service, prepackaged only	~~2,240~~ $2,576
Waste disposal	~~1,520~~ $1,748
Distribution - general licensed devices (sealed sources)	~~880~~ $1,012
Distribution - general licensed material (unsealed sources)	~~520~~ $598
Industrial radiography - fixed or temporary location	~~2,640~~ $3,036
~~Industrial radiography - temporary job sites~~	~~2,640~~
Irradiators, self-shielding~~, less than 10,000 curies~~	~~1,440~~ $1,656
Irradiators, other, less than 10,000 curies	~~2,960~~ $3,404
~~Irradiators, self-shielding, 10,000 curies or more~~	~~1,440~~
Research and development - type A, B, or C broad scope	~~4,960~~ $5,704
~~Research and development - type B broad scope~~	~~4,960~~
~~Research and development - type C broad scope~~	~~4,960~~
Research and development - other	~~2,400~~ $2,760
Storage - no operations	~~960~~ $1,104
Source material - shielding	~~136~~ $156
Special nuclear material plutonium - neutron source in device	~~1,200~~ $1,380
Pacemaker by-product and/or special nuclear material - medical (institution)	~~1,200~~ $1,380
Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~2,320~~ $2,668
Accelerator-produced radioactive material	~~4,100~~ $4,715
Nonprofit educational institutions	~~300~~ $345
~~General license registration~~	~~0~~
~~Industrial radiographer certification~~	~~150~~

Sec. 30. Minnesota Statutes 2020, section 144.1205, subdivision 8, is amended to read:

Subd. 8. **Reciprocity fee.** A licensee submitting an application for reciprocal recognition of a materials license issued by another agreement state or the United States Nuclear Regulatory Commission for a period of 180 days or less during a calendar year must pay ~~$1,200~~ $2,400. For a period of 181 days or more, the licensee must obtain a license under subdivision 4.

Sec. 31. Minnesota Statutes 2020, section 144.1205, subdivision 9, is amended to read:

Subd. 9. **Fees for license amendments.** A licensee must pay a fee of ~~$300~~ $600 to amend a license as follows:

(1) to amend a license requiring review including, but not limited to, addition of isotopes, procedure changes, new authorized users, or a new radiation safety officer; and

(2) to amend a license requiring review and a site visit including, but not limited to, facility move or addition of processes.

Sec. 32. Minnesota Statutes 2020, section 144.1205, is amended by adding a subdivision to read:

Subd. 10. **Fees for general license registrations.** A person required to register generally licensed devices according to Minnesota Rules, part 4731.3215, must pay an annual registration fee of $450.

Sec. 33. Minnesota Statutes 2020, section 144.125, subdivision 1, is amended to read:

Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health.

(b) Testing, recording of test results, reporting of test results, and follow-up of infants with heritable congenital disorders, including hearing loss detected through the early hearing detection and intervention program in section 144.966, shall be performed at the times and in the manner prescribed by the commissioner of health.

(c) The fee to support the newborn screening program, including tests administered under this section and section 144.966, shall be ~~$135~~ $177 per specimen. This fee amount

shall be deposited in the state treasury and credited to the state government special revenue fund.

(d) The fee to offset the cost of the support services provided under section 144.966, subdivision 3a, shall be $15 per specimen. This fee shall be deposited in the state treasury and credited to the general fund.

Sec. 34. **[144.1461] DIGNITY IN PREGNANCY AND CHILDBIRTH.**

Subdivision 1. **Citation.** This section may be cited as the "Dignity in Pregnancy and Childbirth Act."

Subd. 2. **Continuing education requirement.** (a) Hospitals with obstetric care and birth centers must provide continuing education on anti-racism training and implicit bias. The continuing education must be evidence-based and must include at a minimum the following criteria:

(1) education aimed at identifying personal, interpersonal, institutional, structural, and cultural barriers to inclusion;

(2) identifying and implementing corrective measures to promote anti-racism practices and decrease implicit bias at the interpersonal and institutional levels, including the institution's ongoing policies and practices;

(3) providing information on the ongoing effects of historical and contemporary exclusion and oppression of Black and Indigenous communities with the greatest health disparities related to maternal and infant mortality and morbidity;

(4) providing information and discussion of health disparities in the perinatal health care field including how systemic racism and implicit bias have different impacts on health outcomes for different racial and ethnic communities; and

(5) soliciting perspectives of diverse, local constituency groups and experts on racial, identity, cultural, and provider-community relationship issues.

(b) In addition to the initial continuing educational requirement in paragraph (a), hospitals with obstetric care and birth centers must provide an annual refresher course that reflects current trends on race, culture, identity, and anti-racism principles and institutional implicit bias.

(c) Hospitals with obstetric care and birth centers must develop continuing education materials on anti-racism and implicit bias that must be provided and updated annually for

direct care employees and contractors who routinely care for patients who are pregnant or postpartum.

(d) Hospitals with obstetric care and birth centers shall coordinate with health-related licensing boards to obtain continuing education credits for the trainings and materials required in this section. The commissioner of health shall monitor compliance with this section. Initial training for the continuing education requirements in this subdivision must be completed by December 31, 2022. The commissioner may inspect the training records or require reports on the continuing education materials in this section from hospitals with obstetric care and birth centers.

(e) A facility described in paragraph (d) must provide a certificate of training completion to another facility or a training attendee upon request. A facility may accept the training certificate from another facility for a health care provider that works in more than one facility.

Sec. 35. Minnesota Statutes 2020, section 144.1481, subdivision 1, is amended to read:

Subdivision 1. **Establishment; membership.** The commissioner of health shall establish a ~~15-member~~ 16-member Rural Health Advisory Committee. The committee shall consist of the following members, all of whom must reside outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2:

(1) two members from the house of representatives of the state of Minnesota, one from the majority party and one from the minority party;

(2) two members from the senate of the state of Minnesota, one from the majority party and one from the minority party;

(3) a volunteer member of an ambulance service based outside the seven-county metropolitan area;

(4) a representative of a hospital located outside the seven-county metropolitan area;

(5) a representative of a nursing home located outside the seven-county metropolitan area;

(6) a medical doctor or doctor of osteopathic medicine licensed under chapter 147;

(7) an oral health professional licensed under chapter 150A;

(8) a midlevel practitioner;

~~(8)~~ (9) a registered nurse or licensed practical nurse;

~~(9)~~ (10) a licensed health care professional from an occupation not otherwise represented on the committee;

~~(10)~~ (11) a representative of an institution of higher education located outside the seven-county metropolitan area that provides training for rural health care providers; and

~~(11)~~ (12) three consumers, at least one of whom must be an advocate for persons who are mentally ill or developmentally disabled.

The commissioner will make recommendations for committee membership. Committee members will be appointed by the governor. In making appointments, the governor shall ensure that appointments provide geographic balance among those areas of the state outside the seven-county metropolitan area. The chair of the committee shall be elected by the members. The advisory committee is governed by section 15.059, except that the members do not receive per diem compensation.

Sec. 36. Minnesota Statutes 2020, section 144.1911, subdivision 6, is amended to read:

Subd. 6. **International medical graduate primary care residency grant program and revolving account.** (a) The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. No grant shall exceed $150,000 per residency position per year. Eligible primary care residency grant recipients include accredited family medicine, general surgery, internal medicine, obstetrics and gynecology, psychiatry, and pediatric residency programs. Eligible primary care residency programs shall apply to the commissioner. Applications must include the number of anticipated residents to be funded using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires. Before any funds are distributed, a grant recipient shall provide the commissioner with the following:

(1) a copy of the signed contract between the primary care residency program and the participating international medical graduate;

(2) certification that the participating international medical graduate has lived in Minnesota for at least two years and is certified by the Educational Commission on Foreign Medical Graduates. Residency programs may also require that participating international medical graduates hold a Minnesota certificate of clinical readiness for residency, once the certificates become available; and

(3) verification that the participating international medical graduate has executed a participant agreement pursuant to paragraph (b).

(b) Upon acceptance by a participating residency program, international medical graduates shall enter into an agreement with the commissioner to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of postresidency employment. Participants shall pay $15,000 or ten percent of their annual compensation each year, whichever is less.

(c) A revolving international medical graduate residency account is established as an account in the special revenue fund in the state treasury. The commissioner of management and budget shall credit to the account appropriations, payments, and transfers to the account. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the account. Funds in the account are appropriated annually to the commissioner to award grants and administer the grant program established in paragraph (a). Notwithstanding any law to the contrary, any funds deposited in the account do not expire. The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any grant issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the account, as well as the amount of the contribution provided; and

(3) a contributing entity may not specify that the recipient or recipients of any funds use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

Sec. 37. Minnesota Statutes 2020, section 144.212, is amended by adding a subdivision to read:

Subd. 12. **Homeless youth.** "Homeless youth" has the meaning given in section 256K.45, subdivision 1a.

Sec. 38. Minnesota Statutes 2020, section 144.225, subdivision 2, is amended to read:

Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data pertaining to the birth of a child to a woman who was not married to the child's father when the child was conceived nor when the child was born, including the original record of birth and the certified vital record, are confidential data. At the time of the birth of a child to a

woman who was not married to the child's father when the child was conceived nor when the child was born, the mother may designate demographic data pertaining to the birth as public. Notwithstanding the designation of the data as confidential, it may be disclosed:

(1) to a parent or guardian of the child;

(2) to the child when the child is 16 years of age or older, except as provided in clause (3);

(3) to the child if the child is a homeless youth;

~~(3)~~ (4) under paragraph (b), (e), or (f); or

~~(4)~~ (5) pursuant to a court order. For purposes of this section, a subpoena does not constitute a court order.

(b) Unless the child is adopted, data pertaining to the birth of a child that are not accessible to the public become public data if 100 years have elapsed since the birth of the child who is the subject of the data, or as provided under section 13.10, whichever occurs first.

(c) If a child is adopted, data pertaining to the child's birth are governed by the provisions relating to adoption records, including sections 13.10, subdivision 5; 144.218, subdivision 1; 144.2252; and 259.89.

(d) The name and address of a mother under paragraph (a) and the child's date of birth may be disclosed to the county social services, tribal health department, or public health member of a family services collaborative for purposes of providing services under section 124D.23.

(e) The commissioner of human services shall have access to birth records for:

(1) the purposes of administering medical assistance and the MinnesotaCare program;

(2) child support enforcement purposes; and

(3) other public health purposes as determined by the commissioner of health.

(f) Tribal child support programs shall have access to birth records for child support enforcement purposes.

Sec. 39. Minnesota Statutes 2020, section 144.225, subdivision 7, is amended to read:

Subd. 7. **Certified birth or death record.** (a) The state registrar or local issuance office shall issue a certified birth or death record or a statement of no vital record found to an individual upon the individual's proper completion of an attestation provided by the commissioner and, except as provided in section 144.2255, payment of the required fee:

(1) to a person who ~~has a tangible interest in the requested vital record. A person who has a tangible interest~~ is:

(i) the subject of the vital record;

(ii) a child of the subject;

(iii) the spouse of the subject;

(iv) a parent of the subject;

(v) the grandparent or grandchild of the subject;

(vi) if the requested record is a death record, a sibling of the subject;

~~(vii) the party responsible for filing the vital record;~~

~~(viii)~~ (vii) the legal custodian, guardian or conservator, or health care agent of the subject;

~~(ix)~~ (viii) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

~~(x)~~ (ix) a successor of the subject, as defined in section 524.1-201, if the subject is deceased, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

~~(xi)~~ (x) if the requested record is a death record, a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust;

~~(xii)~~ (xi) a person or entity who demonstrates that a certified vital record is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner; or

~~(xiii)~~ (xii) an adoption agency in order to complete confidential postadoption searches as required by section 259.83;

(2) to any local, state, tribal, or federal governmental agency upon request if the certified vital record is necessary for the governmental agency to perform its authorized duties;

(3) to an attorney representing the subject of the vital record or another person listed in clause (1), upon evidence of the attorney's license;

(4) pursuant to a court order issued by a court of competent jurisdiction. For purposes of this section, a subpoena does not constitute a court order; or

(5) to a representative authorized by a person under clauses (1) to (4).

(b) The state registrar or local issuance office shall also issue a certified death record to an individual described in paragraph (a), clause (1), items (ii) to ~~(viii)~~ (xi), if, on behalf of the individual, a licensed mortician furnishes the registrar with a properly completed attestation in the form provided by the commissioner within 180 days of the time of death of the subject of the death record. This paragraph is not subject to the requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

Sec. 40. **[144.2255] CERTIFIED BIRTH RECORD FOR HOMELESS YOUTH.**

Subdivision 1. **Application; certified birth record.** A subject of a birth record who is a homeless youth in Minnesota or another state may apply to the state registrar or a local issuance office for a certified birth record according to this section. The state registrar or local issuance office shall issue a certified birth record or statement of no vital record found to a subject of a birth record who submits:

(1) a completed application signed by the subject of the birth record;

(2) a statement that the subject of the birth record is a homeless youth, signed by the subject of the birth record; and

(3) one of the following:

(i) a document of identity listed in Minnesota Rules, part 4601.2600, subpart 8 or, at the discretion of the state registrar or local issuance office, subpart 9;

(ii) a statement that complies with Minnesota Rules, part 4601.2600, subparts 6 and 7; or

(iii) a statement verifying that the subject of the birth record is a homeless youth that complies with the requirements in subdivision 2 and is from an employee of a human services agency that receives public funding to provide services to homeless youth, runaway youth, youth with mental illness, or youth with substance use disorders; a school staff person who provides services to homeless youth; or a school social worker.

Subd. 2. **Statement verifying subject is a homeless youth.** A statement verifying that a subject of a birth record is a homeless youth must include:

(1) the following information regarding the individual providing the statement: first name, middle name, if any, and last name; home or business address; telephone number, if any; and e-mail address, if any;

(2) the first name, middle name, if any, and last name of the subject of the birth record; and

(3) a statement specifying the relationship of the individual providing the statement to the subject of the birth record and verifying that the subject of the birth record is a homeless youth.

The individual providing the statement must also provide a copy of the individual's employment identification.

Subd. 3. **Expiration; reissuance.** If a subject of a birth record obtains a certified birth record under this section using the statement specified in subdivision 1, clause (3), item (iii), the certified birth record issued shall expire six months after the date of issuance. Upon expiration of the certified birth record, the subject of the birth record may surrender the expired birth record to the state registrar or a local issuance office and obtain another birth record. Each certified birth record obtained under this subdivision shall expire six months after the date of issuance. If the subject of the birth record does not surrender the expired birth record, the subject may apply for a certified birth record using the process in subdivision 1.

Subd. 4. **Fees waived.** The state registrar or local issuance office shall not charge any fee for issuance of a certified birth record or statement of no vital record found under this section.

Subd. 5. **Data practices.** Data listed under subdivision 1, clauses (2) and (3), item (iii), are private data on individuals.

EFFECTIVE DATE. This section is effective the day following final enactment for applications for and the issuance of certified birth records on or after January 1, 2022.

Sec. 41. Minnesota Statutes 2020, section 144.226, is amended by adding a subdivision to read:

Subd. 7. **Transaction fees.** The state registrar may charge and permit agents to charge a convenience fee and a transaction fee for electronic transactions and transactions by telephone or Internet, as well as the fees established under subdivisions 1, 2, 3, and 4. The convenience fee may not exceed three percent of the cost of the charges for payment. The state registrar may permit agents to charge and retain a transaction fee as payment agreed upon under contract. When an electronic convenience fee or transaction fee is charged, the agent charging the fee is required to post information on their web page informing individuals of the fee. The information must be near the point of payment, clearly visible, include the amount of the fee, and state: "This contracted agent is allowed by state law to charge a convenience fee and transaction fee for this electronic transaction."

Sec. 42. Minnesota Statutes 2020, section 144.226, is amended by adding a subdivision to read:

Subd. 8. **Birth record fees waived for homeless youth.** A subject of a birth record who is a homeless youth shall not be charged any of the fees specified in subdivisions 1 and 3 to 6 for a certified birth record or statement of no vital record found under section 144.2255.

EFFECTIVE DATE. This section is effective the day following final enactment for applications for and the issuance of certified birth records on or after January 1, 2022.

Sec. 43. Minnesota Statutes 2020, section 144.55, subdivision 4, is amended to read:

Subd. 4. **Routine inspections; presumption.** Any hospital surveyed and accredited under the standards of the hospital accreditation program of an approved accrediting organization that submits to the commissioner within a reasonable time copies of (a) its currently valid accreditation certificate and accreditation letter, together with accompanying recommendations and comments and (b) any further recommendations, progress reports and correspondence directly related to the accreditation is presumed to comply with application requirements of subdivision 1 and the standards requirements of subdivision 3 and no further routine inspections or accreditation information shall be required by the commissioner to determine compliance. Notwithstanding the provisions of sections 144.54 and 144.653, subdivisions 2 and 4, hospitals shall be inspected only as provided in this section. The provisions of section 144.653 relating to the assessment and collection of fines shall not apply to any hospital. The commissioner of health shall annually conduct, with notice, validation inspections of a selected sample of the number of hospitals accredited by an approved accrediting organization, not to exceed ten percent of accredited hospitals, for the purpose of determining compliance with the provisions of subdivision 3. If a validation survey discloses a failure to comply with subdivision 3, the provisions of section 144.653 relating to correction orders, reinspections, and notices of noncompliance shall apply. The commissioner shall also conduct any inspection necessary to determine whether hospital construction, addition, or remodeling projects comply with standards for construction promulgated in rules pursuant to subdivision 3. The commissioner shall also conduct any inspections necessary to determine whether a hospital or hospital corporate system continues to satisfy the conditions on which a hospital construction moratorium exception was granted under section 144.551. Pursuant to section 144.653, the commissioner shall inspect any hospital that does not have a currently valid hospital accreditation certificate from an approved accrediting organization. Nothing in this subdivision shall be construed to limit

the investigative powers of the Office of Health Facility Complaints as established in sections 144A.51 to 144A.54.

Sec. 44. Minnesota Statutes 2020, section 144.55, subdivision 6, is amended to read:

Subd. 6. **Suspension, revocation, and refusal to renew.** (a) The commissioner may refuse to grant or renew, or may suspend or revoke, a license on any of the following grounds:

(1) violation of any of the provisions of sections 144.50 to 144.56 or the rules or standards issued pursuant thereto, or Minnesota Rules, chapters 4650 and 4675;

(2) permitting, aiding, or abetting the commission of any illegal act in the institution;

(3) conduct or practices detrimental to the welfare of the patient; or

(4) obtaining or attempting to obtain a license by fraud or misrepresentation; or

(5) with respect to hospitals and outpatient surgical centers, if the commissioner determines that there is a pattern of conduct that one or more physicians or advanced practice registered nurses who have a "financial or economic interest," as defined in section 144.6521, subdivision 3, in the hospital or outpatient surgical center, have not provided the notice and disclosure of the financial or economic interest required by section 144.6521.

(b) The commissioner shall not renew a license for a boarding care bed in a resident room with more than four beds.

(c) The commissioner shall not renew licenses for hospital beds issued to a hospital or hospital corporate system pursuant to a hospital construction moratorium exception under section 144.551 if the commissioner determines the hospital or hospital corporate system is not satisfying the conditions on which the exception was granted.

EFFECTIVE DATE. This section is effective for license renewals occurring on or after July 1, 2021.

Sec. 45. Minnesota Statutes 2020, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; ~~and~~ (iv) the relocation or redistribution does not involve the construction of a new hospital building; and (v) the

transferred beds are used first to replace within the hospital corporate system the total number of beds previously used in the closed facility site or complex for mental health services and substance use disorder services. Only after the hospital corporate system has fulfilled the requirements of item (v) may the remainder of the available capacity of the closed facility site or complex be transferred for any other purpose;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds in an existing hospital in Carver County serving the southwest suburban metropolitan area;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

(19) a critical access hospital established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law;

(20) notwithstanding section 144.552, a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

(i) the project, including each hospital or health system that will own or control the entity that will hold the new hospital license, is approved by a resolution of the Maple Grove City Council as of March 1, 2006;

(ii) the entity that will hold the new hospital license will be owned or controlled by one or more not-for-profit hospitals or health systems that have previously submitted a plan or plans for a project in Maple Grove as required under section 144.552, and the plan or plans have been found to be in the public interest by the commissioner of health as of April 1, 2005;

(iii) the new hospital's initial inpatient services must include, but are not limited to, medical and surgical services, obstetrical and gynecological services, intensive care services, orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health services, and emergency room services;

(iv) the new hospital:

(A) will have the ability to provide and staff sufficient new beds to meet the growing needs of the Maple Grove service area and the surrounding communities currently being served by the hospital or health system that will own or control the entity that will hold the new hospital license;

(B) will provide uncompensated care;

(C) will provide mental health services, including inpatient beds;

(D) will be a site for workforce development for a broad spectrum of health-care-related occupations and have a commitment to providing clinical training programs for physicians and other health care providers;

(E) will demonstrate a commitment to quality care and patient safety;

(F) will have an electronic medical records system, including physician order entry;

(G) will provide a broad range of senior services;

(H) will provide emergency medical services that will coordinate care with regional providers of trauma services and licensed emergency ambulance services in order to enhance the continuity of care for emergency medical patients; and

(I) will be completed by December 31, 2009, unless delayed by circumstances beyond the control of the entity holding the new hospital license; and

(v) as of 30 days following submission of a written plan, the commissioner of health has not determined that the hospitals or health systems that will own or control the entity that will hold the new hospital license are unable to meet the criteria of this clause;

(21) a project approved under section 144.553;

(22) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board;

(23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility;

(24) notwithstanding section 144.552, a project for the construction and expansion of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients who are under 21 years of age on the date of admission. The commissioner conducted a public interest review of the mental health needs of Minnesota and the Twin Cities metropolitan area in 2008. No further public interest review shall be conducted for the construction or expansion project under this clause;

(25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city of Maple Grove, exclusively for patients who are under 21 years of age on the date of

admission, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(ii) this project shall serve patients in the continuing care benefit program under section 256.9693. The project may also serve patients not in the continuing care benefit program; and

(iii) if the project ceases to participate in the continuing care benefit program, the commissioner must complete a subsequent public interest review under section 144.552. If the project is found not to be in the public interest, the license must be terminated six months from the date of that finding. If the commissioner of human services terminates the contract without cause or reduces per diem payment rates for patients under the continuing care benefit program below the rates in effect for services provided on December 31, 2015, the project may cease to participate in the continuing care benefit program and continue to operate without a subsequent public interest review;

(27) a project involving the addition of 21 new beds in an existing psychiatric hospital in Hennepin County that is exclusively for patients who are under 21 years of age on the date of admission; ~~or~~

(28) a project to add 55 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which 15 beds are to be used for inpatient mental health and 40 are to be used for other services. In addition, five unlicensed observation mental health beds shall be added~~.~~;

(29) notwithstanding section 144.552, a project to add 45 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5. The commissioner conducted a public interest review of the construction and expansion of this hospital in 2018. No further public interest review shall be conducted for the project under this clause; or

(30) the addition of licensed beds in a hospital or hospital corporate system to primarily provide mental health services or substance use disorder services. In order to add beds under this clause, a hospital must have an emergency department and must not be a hospital that solely provides treatment to adults for mental illnesses or substance use disorders. Beds added under this clause must be available to serve medical assistance and MinnesotaCare enrollees. Notwithstanding section 144.552, public interest review shall not be required for an addition of beds under this clause.

EFFECTIVE DATE. (a) Paragraph (b), clause (29), is effective the day following final enactment, contingent upon:

(1) the addition of the 15 inpatient mental health beds specified in paragraph (b), clause (28), to the Ramsey County level I trauma center's bed capacity;

(2) five of the 45 additional beds authorized in paragraph (b), clause (29), being designated for use for inpatient mental health and added to the hospital's bed capacity before the remaining 40 beds authorized under that clause are added; and

(3) the Ramsey County level I trauma center's agreement to not participate in the Revenue Recapture Act under Minnesota Statutes, chapter 270, and Minnesota Statutes, section 270C.41.

(b) The amendment to paragraph (b), clause (8), and paragraph (b), clause (30), are effective the day following final enactment.

Sec. 46. Minnesota Statutes 2020, section 144.551, is amended by adding a subdivision to read:

Subd. 5. **Monitoring.** The commissioner shall monitor the implementation of exceptions under this section. Each hospital or hospital corporate system granted an exception under this section shall submit to the commissioner each year a report on how the hospital or hospital corporate system continues to satisfy the conditions on which the exception was granted.

Sec. 47. Minnesota Statutes 2020, section 144.555, is amended to read:

144.555 ~~HOSPITAL~~ FACILITY OR CAMPUS CLOSINGS, RELOCATING SERVICES, OR CEASING TO OFFER CERTAIN SERVICES; PATIENT RELOCATIONS.

Subdivision 1. **Notice of closing or curtailing ~~service~~ operations; facilities other than hospitals.** If a facility licensed under sections 144.50 to 144.56, other than a hospital, voluntarily plans to cease operations or to curtail operations to the extent that patients or residents must be relocated, the controlling persons of the facility must notify the commissioner of health at least 90 days before the scheduled cessation or curtailment. The commissioner shall cooperate with the controlling persons and advise them about relocating the patients or residents.

Subd. 1a. **Notice of closing, curtailing operations, relocating services, or ceasing to offer certain services; hospitals.** (a) The controlling persons of a hospital licensed under sections 144.50 to 144.56 or a hospital campus must notify the commissioner of health at

least nine months before a scheduled action if the hospital or hospital campus voluntarily plans to:

(1) cease operations;

(2) curtail operations to the extent that patients must be relocated;

(3) relocate the provision of health services to another hospital or another hospital campus; or

(4) cease offering maternity care and newborn care services, intensive care unit services, inpatient mental health services, or inpatient substance use disorder treatment services.

(b) The commissioner shall cooperate with the controlling persons and advise them about relocating the patients. The controlling persons of the hospital or hospital campus must comply with section 144.556.

Subd. 1b. **Public hearing.** Upon receiving notice under subdivision 1a, the commissioner shall conduct a public hearing on the scheduled cessation of operations, curtailment of operations, relocation of health services, or cessation in offering health services. The commissioner must provide adequate public notice of the hearing in a time and manner determined by the commissioner. The public hearing must be held in the community where the hospital or hospital campus is located at least six months before the scheduled cessation or curtailment of operations, relocation of health services, or cessation in offering health services. The controlling persons of the hospital or hospital campus must participate in the public hearing. The public hearing must include:

(1) an explanation by the controlling persons of the reasons for ceasing or curtailing operations, relocating health services, or ceasing to offer any of the listed health services;

(2) a description of the actions that controlling persons will take to ensure that residents in the hospital's or campus's service area have continued access to the health services being eliminated, curtailed, or relocated;

(3) an opportunity for public testimony on the scheduled cessation or curtailment of operations, relocation of health services, or cessation in offering any of the listed health services, and on the hospital's or campus's plan to ensure continued access to those health services being eliminated, curtailed, or relocated; and

(4) an opportunity for the controlling persons to respond to questions from interested persons.

Subd. 2. **Penalty.** Failure to notify the commissioner under subdivision 1 or 1a or failure to participate in a public hearing under subdivision 1b may result in issuance of a correction order under section 144.653, subdivision 5.

Sec. 48. **[144.556] RIGHT OF FIRST REFUSAL FOR HOSPITAL OR HOSPITAL CAMPUS.**

Subdivision 1. **Prerequisite before sale, conveyance, or ceasing operations of hospital or hospital campus.** The controlling persons of a hospital licensed under sections 144.50 to 144.56 shall not sell or convey the hospital or a campus of the hospital, offer to sell or convey the hospital or hospital campus, or voluntarily cease operations of the hospital or hospital campus unless the controlling persons have first made a good faith offer to sell or convey the hospital or hospital campus to the home rule charter or statutory city, county, town, or hospital district in which the hospital or hospital campus is located.

Subd. 2. **Offer.** The offer to sell or convey the hospital or hospital campus must be at a price that does not exceed the current fair market value of the hospital or hospital campus. A party to whom an offer is made under subdivision 1 must accept or decline the offer within 60 days after receipt. If the party fails to respond within 60 days after receipt, the offer is deemed declined.

Sec. 49. Minnesota Statutes 2020, section 144.9501, subdivision 17, is amended to read:

Subd. 17. **Lead hazard reduction.** "Lead hazard reduction" means abatement or interim controls undertaken to make a residence, child care facility, school, ~~or~~ playground, or other location where lead hazards are identified lead-safe by complying with the lead standards and methods adopted under section 144.9508.

Sec. 50. Minnesota Statutes 2020, section 144.9502, subdivision 3, is amended to read:

Subd. 3. **Reports of blood lead analysis required.** (a) Every hospital, medical clinic, medical laboratory, other facility, or individual performing blood lead analysis shall report the results after the analysis of each specimen analyzed, for both capillary and venous specimens, and epidemiologic information required in this section to the commissioner of health, within the time frames set forth in clauses (1) and (2):

(1) within two working days by telephone, fax, or electronic transmission as prescribed by the commissioner, with written or electronic confirmation within one month as prescribed by the commissioner, for a venous blood lead level equal to or greater than 15 micrograms of lead per deciliter of whole blood; or

(2) within one month in writing or by electronic transmission as prescribed by the commissioner, for any capillary result or for a venous blood lead level less than 15 micrograms of lead per deciliter of whole blood.

(b) If a blood lead analysis is performed outside of Minnesota and the facility performing the analysis does not report the blood lead analysis results and epidemiological information required in this section to the commissioner, the provider who collected the blood specimen must satisfy the reporting requirements of this section. For purposes of this section, "provider" has the meaning given in section 62D.02, subdivision 9.

(c) The commissioner shall coordinate with hospitals, medical clinics, medical laboratories, and other facilities performing blood lead analysis to develop a universal reporting form and mechanism.

Sec. 51. Minnesota Statutes 2020, section 144.9504, subdivision 2, is amended to read:

Subd. 2. **Lead risk assessment.** (a) Notwithstanding section 144.9501, subdivision 6a, for purposes of this subdivision, "child" means an individual under 18 years of age.

(b) An assessing agency shall conduct a lead risk assessment of a residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected according to the venous blood lead level and time frame set forth in clauses (1) to (4) for purposes of secondary prevention:

(1) within 48 hours of a child or pregnant female in the residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected being identified to the agency as having a venous blood lead level equal to or greater than 60 micrograms of lead per deciliter of whole blood;

(2) within five working days of a child or pregnant female in the residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected being identified to the agency as having a venous blood lead level equal to or greater than 45 micrograms of lead per deciliter of whole blood;

~~(3) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level equal to or greater than 15 micrograms of lead per deciliter of whole blood; or~~

~~(4)~~ (3) within ten working days of a child or pregnant female in the residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected being identified to the agency as having a venous blood lead level equal to or greater than ten micrograms of lead per deciliter of whole blood~~.~~; or

(4) within 20 working days of a child or pregnant female in the residence, residential or commercial child care facility, playground, school, or other location where lead hazards are suspected being identified to the agency as having a venous blood lead level equal to or greater than five micrograms per deciliter of whole blood.

~~(b)~~ (c) Within the limits of available local, state, and federal appropriations, an assessing agency may also conduct a lead risk assessment for children with any elevated blood lead level.

~~(c)~~ (d) In a building with two or more dwelling units, an assessing agency shall assess the individual unit in which the conditions of this section are met and shall inspect all common areas accessible to a child. If a child visits one or more other sites such as another residence, or a residential or commercial child care facility, playground, or school, the assessing agency shall also inspect the other sites. The assessing agency shall have one additional day added to the time frame set forth in this subdivision to complete the lead risk assessment for each additional site.

~~(d)~~ (e) Within the limits of appropriations, the assessing agency shall identify the known addresses for the previous 12 months of the child or pregnant female with venous blood lead levels of at least 15 micrograms per deciliter for the child or at least ten micrograms per deciliter for the pregnant female; notify the property owners, landlords, and tenants at those addresses that an elevated blood lead level was found in a person who resided at the property; and give them primary prevention information. Within the limits of appropriations, the assessing agency may perform a risk assessment and issue corrective orders in the properties, if it is likely that the previous address contributed to the child's or pregnant female's blood lead level. The assessing agency shall provide the notice required by this subdivision without identifying the child or pregnant female with the elevated blood lead level. The assessing agency is not required to obtain the consent of the child's parent or guardian or the consent of the pregnant female for purposes of this subdivision. This information shall be classified as private data on individuals as defined under section 13.02, subdivision 12.

~~(e)~~ (f) The assessing agency shall conduct the lead risk assessment according to rules adopted by the commissioner under section 144.9508. An assessing agency shall have lead risk assessments performed by lead risk assessors licensed by the commissioner according to rules adopted under section 144.9508. If a property owner refuses to allow a lead risk assessment, the assessing agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead risk assessment set forth in this subdivision no longer applies. A lead risk assessor or assessing agency may observe the performance of

lead hazard reduction in progress and shall enforce the provisions of this section under section 144.9509. Deteriorated painted surfaces, bare soil, and dust must be tested with appropriate analytical equipment to determine the lead content, except that deteriorated painted surfaces or bare soil need not be tested if the property owner agrees to engage in lead hazard reduction on those surfaces. The lead content of drinking water must be measured if another probable source of lead exposure is not identified. Within a standard metropolitan statistical area, an assessing agency may order lead hazard reduction of bare soil without measuring the lead content of the bare soil if the property is in a census tract in which soil sampling has been performed according to rules established by the commissioner and at least 25 percent of the soil samples contain lead concentrations above the standard in section 144.9508.

~~(f)~~ (g) Each assessing agency shall establish an administrative appeal procedure which allows a property owner to contest the nature and conditions of any lead order issued by the assessing agency. Assessing agencies must consider appeals that propose lower cost methods that make the residence lead safe. The commissioner shall use the authority and appeal procedure granted under sections 144.989 to 144.993.

~~(g)~~ (h) Sections 144.9501 to 144.9512 neither authorize nor prohibit an assessing agency from charging a property owner for the cost of a lead risk assessment.

Sec. 52. Minnesota Statutes 2020, section 144.9504, subdivision 5, is amended to read:

Subd. 5. **Lead orders.** (a) An assessing agency, after conducting a lead risk assessment, shall order a property owner to perform lead hazard reduction on all lead sources that exceed a standard adopted according to section 144.9508. If lead risk assessments and lead orders are conducted at times when weather or soil conditions do not permit the lead risk assessment or lead hazard reduction, external surfaces and soil lead shall be assessed, and lead orders complied with, if necessary, at the first opportunity that weather and soil conditions allow.

(b) If, after conducting a lead risk assessment, an assessing agency determines that the property owner's lead hazard originated from another source location, the assessing agency may order the responsible person of the source location to:

(1) perform lead hazard reduction at the site where the assessing agency conducted the lead risk assessment; and

(2) remediate the conditions at the source location that allowed the lead hazard, pollutant, or contaminant to migrate from the source location.

For purposes of this subdivision, "pollutant or contaminant" has the meaning given in section 115B.02, subdivision 13, and "responsible person" has the meaning given in section 115B.03.

~~(b)~~ (c) If the paint standard under section 144.9508 is violated, but the paint is intact, the assessing agency shall not order the paint to be removed unless the intact paint is a known source of actual lead exposure to a specific person. Before the assessing agency may order the intact paint to be removed, a reasonable effort must be made to protect the child and preserve the intact paint by the use of guards or other protective devices and methods.

~~(c)~~ (d) Whenever windows and doors or other components covered with deteriorated lead-based paint have sound substrate or are not rotting, those components should be repaired, sent out for stripping or planed down to remove deteriorated lead-based paint, or covered with protective guards instead of being replaced, provided that such an activity is the least cost method. However, a property owner who has been ordered to perform lead hazard reduction may choose any method to address deteriorated lead-based paint on windows, doors, or other components, provided that the method is approved in rules adopted under section 144.9508 and that it is appropriate to the specific property.

~~(d)~~ (e) Lead orders must require that any source of damage, such as leaking roofs, plumbing, and windows, be repaired or replaced, as needed, to prevent damage to lead-containing interior surfaces.

~~(e)~~ (f) The assessing agency is not required to pay for lead hazard reduction. The assessing agency shall enforce the lead orders issued to a property owner under this section.

Sec. 53. Minnesota Statutes 2020, section 144G.08, subdivision 7, as amended by Laws 2020, Seventh Special Session chapter 1, article 6, section 5, is amended to read:

Subd. 7. **Assisted living facility.** "Assisted living facility" means ~~a facility that~~ an establishment where an operating person or legal entity, either directly or through contract, business relationship, common ownership, or other arrangement with another person or entity, provides sleeping accommodations and assisted living services to one or more adults in the facility. Assisted living facility includes assisted living facility with dementia care, and does not include:

(1) emergency shelter, transitional housing, or any other residential units serving exclusively or primarily homeless individuals, as defined under section 116L.361;

(2) a nursing home licensed under chapter 144A;

(3) a hospital, certified boarding care, or supervised living facility licensed under sections 144.50 to 144.56;

(4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, or under chapter 245D or 245G;

(5) services and residential settings licensed under chapter 245A, including adult foster care and services and settings governed under the standards in chapter 245D;

(6) a private home in which the residents are related by kinship, law, or affinity with the provider of services;

(7) a duly organized condominium, cooperative, and common interest community, or owners' association of the condominium, cooperative, and common interest community where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units;

(8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593;

(9) a setting offering services conducted by and for the adherents of any recognized church or religious denomination for its members exclusively through spiritual means or by prayer for healing;

(10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with low-income housing tax credits pursuant to United States Code, title 26, section 42, and units financed by the Minnesota Housing Finance Agency that are intended to serve individuals with disabilities or individuals who are homeless, except for those developments that market or hold themselves out as assisted living facilities and provide assisted living services;

(11) rental housing developed under United States Code, title 42, section 1437, or United States Code, title 12, section 1701q;

(12) rental housing designated for occupancy by only elderly or elderly and disabled residents under United States Code, title 42, section 1437e, or rental housing for qualifying families under Code of Federal Regulations, title 24, section 983.56;

(13) rental housing funded under United States Code, title 42, chapter 89, or United States Code, title 42, section 8011;

~~(14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b);~~ or

~~(15)~~ (14) any establishment that exclusively or primarily serves as a shelter or temporary shelter for victims of domestic or any other form of violence.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 54. Minnesota Statutes 2020, section 144G.84, is amended to read:

144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA.

(a) In addition to the minimum services required in section 144G.41, an assisted living facility with dementia care must also provide the following services:

(1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities;

(2) nonpharmacological practices that are person-centered and evidence-informed;

(3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings; and

(4) services that provide residents with choices for meaningful engagement with other facility residents and the broader community.

(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:

(1) past and current interests;

(2) current abilities and skills;

(3) emotional and social needs and patterns;

(4) physical abilities and limitations;

(5) adaptations necessary for the resident to participate; and

(6) identification of activities for behavioral interventions.

(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.

(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:

(1) occupation or chore related tasks;

(2) scheduled and planned events such as entertainment or outings;

(3) spontaneous activities for enjoyment or those that may help defuse a behavior;

(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;

(5) spiritual, creative, and intellectual activities;

(6) sensory stimulation activities;

(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and

(8) a resident's individualized activity plan for regular outdoor ~~activities~~ activity.

(e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated.

(f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly.

(g) ~~Access to secured outdoor space and walkways that allow residents to enter and return without staff assistance must be provided.~~ Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 55. **[145.87] HOME VISITING FOR PREGNANT WOMEN AND FAMILIES WITH YOUNG CHILDREN.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section and have the meanings given them.

(b) "Evidence-based home visiting program" means a program that:

(1) is based on a clear, consistent program or model that is research-based and grounded in relevant, empirically based knowledge;

(2) is linked to program-determined outcomes and is associated with a national organization, institution of higher education, or national or state public health institute;

(3) has comprehensive home visitation standards that ensure high-quality service delivery and continuous quality improvement;

(4) has demonstrated significant, sustained positive outcomes; and

(5) either:

(i) has been evaluated using rigorous randomized controlled research designs and the evaluation results have been published in a peer-reviewed journal; or

(ii) is based on quasi-experimental research using two or more separate, comparable client samples.

(c) "Evidence-informed home visiting program" means a program that:

(1) has data or evidence demonstrating effectiveness at achieving positive outcomes for pregnant women and young children; and

(2) either:

(i) has an active evaluation of the program; or

(ii) has a plan and timeline for an active evaluation of the program to be conducted.

(d) "Health equity" means every individual has a fair opportunity to attain the individual's full health potential and no individual is disadvantaged from achieving this potential.

(e) "Promising practice home visiting program" means a program that has shown improvement toward achieving positive outcomes for pregnant women or young children.

Subd. 2. **Grants for home visiting programs.** (a) The commissioner of health shall award grants to community health boards, nonprofit organizations, and tribal nations to start up or expand voluntary home visiting programs serving pregnant women and families with young children. Home visiting programs supported under this section shall provide voluntary home visits by early childhood professionals or health professionals, including but not limited to nurses, social workers, early childhood educators, and trained paraprofessionals. Grant money shall be used to:

(1) establish or expand evidence-based, evidence-informed, or promising practice home visiting programs that address health equity and utilize community-driven health strategies;

(2) serve families with young children or pregnant women who have high needs or are high-risk, including but not limited to a family with low income, a parent or pregnant woman with a mental illness or a substance use disorder, or a parent or pregnant woman experiencing housing instability or domestic abuse; and

(3) improve program outcomes in two or more of the following areas:

(i) maternal and newborn health;

(ii) school readiness and achievement;

(iii) family economic self-sufficiency;

(iv) coordination and referral for other community resources and supports;

(v) reduction in child injuries, abuse, or neglect; or

(vi) reduction in crime or domestic violence.

(b) Grants awarded to evidence-informed and promising practice home visiting programs must include money to evaluate program outcomes for up to four of the areas listed in paragraph (a), clause (3).

Subd. 3. **Grant prioritization.** (a) In awarding grants, the commissioner shall give priority to community health boards, nonprofit organizations, and tribal nations seeking to expand home visiting services with community or regional partnerships.

(b) The commissioner shall allocate at least 75 percent of the grant money awarded each grant cycle to evidence-based home visiting programs that address health equity and up to 25 percent of the grant money awarded each grant cycle to evidence-informed or promising practice home visiting programs that address health equity and utilize community-driven health strategies.

Subd. 4. **Administrative costs.** The commissioner may use up to seven percent of the annual appropriation under this section to provide training and technical assistance and to administer and evaluate the program. The commissioner may contract for training, capacity-building support for grantees or potential grantees, technical assistance, and evaluation support.

Subd. 5. **Use of state general fund appropriations.** Appropriations dedicated to establishing or expanding evidence-based home visiting programs shall, for grants awarded on or after July 1, 2021, be awarded according to this section. This section shall not govern grant awards of federal funds for home visiting programs and shall not govern grant awards using state general fund appropriations dedicated to establishing or expanding nurse-family partnership home visiting programs.

Sec. 56. Minnesota Statutes 2020, section 145.893, subdivision 1, is amended to read:

Subdivision 1. ~~**Vouchers**~~ **Food benefits.** An eligible individual shall receive ~~vouchers~~ food benefits for the purchase of specified nutritional supplements in type and quantity approved by the commissioner. Alternate forms of delivery may be developed by the commissioner in appropriate cases.

Sec. 57. Minnesota Statutes 2020, section 145.894, is amended to read:

145.894 STATE COMMISSIONER OF HEALTH; DUTIES, RESPONSIBILITIES.

The commissioner of health shall:

(1) develop a comprehensive state plan for the delivery of nutritional supplements to pregnant and lactating women, infants, and children;

(2) contract with existing local public or private nonprofit organizations for the administration of the nutritional supplement program;

(3) develop and implement a public education program promoting the provisions of sections 145.891 to 145.897, and provide for the delivery of individual and family nutrition education and counseling at project sites. The education programs must include a campaign to promote breast feeding;

(4) develop in cooperation with other agencies and vendors a uniform state ~~voucher~~ food benefit system for the delivery of nutritional supplements;

(5) authorize local health agencies to issue ~~vouchers bimonthly~~ food benefits trimonthly to some or all eligible individuals served by the agency, provided the agency demonstrates that the federal minimum requirements for providing nutrition education will continue to be met and that the quality of nutrition education and health services provided by the agency will not be adversely impacted;

(6) investigate and implement a system to reduce the cost of nutritional supplements and maintain ongoing negotiations with nonparticipating manufacturers and suppliers to maximize cost savings;

(7) develop, analyze, and evaluate the health aspects of the nutritional supplement program and establish nutritional guidelines for the program;

(8) apply for, administer, and annually expend at least 99 percent of available federal or private funds;

(9) aggressively market services to eligible individuals by conducting ongoing outreach activities and by coordinating with and providing marketing materials and technical assistance to local human services and community service agencies and nonprofit service providers;

(10) determine, on July 1 of each year, the number of pregnant women participating in each special supplemental food program for women, infants, and children (WIC) ~~and, in 1986, 1987, and 1988, at the commissioner's discretion, designate a different food program deliverer if the current deliverer fails to increase the participation of pregnant women in the program by at least ten percent over the previous year's participation rate~~;

(11) promulgate all rules necessary to carry out the provisions of sections 145.891 to 145.897; and

(12) ensure that any state appropriation to supplement the federal program is spent consistent with federal requirements.

Sec. 58. Minnesota Statutes 2020, section 145.897, is amended to read:

145.897 ~~VOUCHERS~~ FOOD BENEFITS.

~~Vouchers~~ Food benefits issued pursuant to sections 145.891 to 145.897 shall be only for the purchase of those foods determined by the ~~commissioner~~ United States Department of Agriculture to be desirable nutritional supplements for pregnant and lactating women, infants and children. ~~These foods shall include, but not be limited to, iron fortified infant formula, vegetable or fruit juices, cereal, milk, cheese, and eggs.~~

Sec. 59. Minnesota Statutes 2020, section 145.899, is amended to read:

145.899 WIC ~~VOUCHERS~~ FOOD BENEFITS FOR ORGANICS.

~~Vouchers~~ Food benefits for the special supplemental nutrition program for women, infants, and children (WIC) may be used to purchase cost-neutral organic WIC allowable food. The commissioner of health shall regularly evaluate the list of WIC allowable food in accordance with federal requirements and shall add to the list any organic WIC allowable foods determined to be cost-neutral.

Sec. 60. Minnesota Statutes 2020, section 145.901, subdivision 2, is amended to read:

Subd. 2. **Access to data.** (a) The commissioner of health has access to medical data as defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined in section 13.83, subdivision 1, and health records created, maintained, or stored by providers ~~as defined in section 144.291, subdivision 2, paragraph (i),~~ without the consent of the subject

of the data, and without the consent of the parent, spouse, other guardian, or legal representative of the subject of the data, when the subject of the data is a woman who died during a pregnancy or within 12 months of a fetal death, a live birth, or other termination of a pregnancy.

The commissioner has access only to medical data and health records related to deaths that occur on or after July 1, 2000, including the names of the providers, clinics, or other health services such as family home visiting programs; the women, infants, and children (WIC) program; prescription monitoring programs; and behavioral health services, where care was received before, during, or related to the pregnancy or death. The commissioner has access to records maintained by a medical examiner, a coroner, or hospitals or to hospital discharge data, for the purpose of providing the name and location of any pre-pregnancy, prenatal, or other care received by the subject of the data up to one year after the end of the pregnancy.

(b) The provider or responsible authority that creates, maintains, or stores the data shall furnish the data upon the request of the commissioner. The provider or responsible authority may charge a fee for providing the data, not to exceed the actual cost of retrieving and duplicating the data.

(c) The commissioner shall make a good faith reasonable effort to notify the parent, spouse, other guardian, or legal representative of the subject of the data before collecting data on the subject. For purposes of this paragraph, "reasonable effort" means one notice is sent by certified mail to the last known address of the parent, spouse, guardian, or legal representative informing the recipient of the data collection and offering a public health nurse support visit if desired.

(d) The commissioner does not have access to coroner or medical examiner data that are part of an active investigation as described in section 13.83.

(e) The commissioner may request and receive from a coroner or medical examiner the name of the health care provider that provided prenatal, postpartum, or other health services to the subject of the data.

(f) The commissioner may access Department of Human Services data to identify sources of care and services to assist with the evaluation of welfare systems, including housing, to reduce preventable maternal deaths.

(g) The commissioner may request and receive law enforcement reports or incident reports related to the subject of the data.

Sec. 61. Minnesota Statutes 2020, section 145.901, subdivision 4, is amended to read:

Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source records under subdivision 2, including identifying information on individual providers, data subjects, or their children, and data derived by the commissioner under subdivision 3 for the purpose of carrying out maternal death studies, are classified as confidential data on individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3, and 13.10, subdivision 1, paragraph (a).

(b) Information classified under paragraph (a) shall not be subject to discovery or introduction into evidence in any administrative, civil, or criminal proceeding. Such information otherwise available from an original source shall not be immune from discovery or barred from introduction into evidence merely because it was utilized by the commissioner in carrying out maternal death studies.

(c) Summary data on maternal death studies created by the commissioner, which does not identify individual data subjects or individual providers, shall be public in accordance with section 13.05, subdivision 7.

(d) Data provided by the commissioner of human services to the commissioner of health under this section retains the same classification the data held when retained by the commissioner of human services, as required under section 13.03, subdivision 4, paragraph (c).

Sec. 62. **[145.9013] SEVERE MATERNAL MORBIDITY STUDIES.**

Subdivision 1. **Purpose.** (a) The commissioner of health may conduct maternal morbidity studies to assist the planning, implementation, and evaluation of medical, health, and welfare service systems and to reduce the numbers of preventable adverse maternal outcomes in Minnesota.

(b) For purposes of this section, "maternal morbidity" has the meaning given to severe maternal morbidity by the Centers for Disease Control and Prevention and includes an unexpected outcome of labor or delivery that results in significant short- or long-term consequences to a woman's health.

Subd. 2. **Access to data.** (a) The commissioner has access to medical data as defined in section 13.384, subdivision 1, paragraph (b), and health records created, maintained, or stored by providers when the subject of the data experienced one or more maternal morbidities during a pregnancy or within 12 months of the end of a pregnancy. The commissioner has access only to medical data and health records related to maternal

morbidities that occur on or after January 1, 2015, including the names of providers and clinics where care was received before, during, or related to the pregnancy. The commissioner has access to records maintained by family home visiting programs; the women, infants, and children (WIC) program; prescription monitoring programs; behavioral health services programs; substance use disorder treatment facilities; and hospitals for the purpose of providing the name and location of any pre-pregnancy, prenatal, or other care received by the subject of the data up to one year following the end of the pregnancy.

(b) The provider or responsible authority that creates, maintains, or stores the data under paragraph (a) shall provide the commissioner with access to information on each maternal morbidity case in the manner and at times that the commissioner designates. The provider or responsible authority may charge a fee for providing the data, not to exceed the actual cost of retrieving and duplicating the data.

(c) Once the commissioner has determined that the subject of the data meets the criteria in paragraph (a) for a maternal morbidity review, the commissioner must inform the subject of the data about the collection of the subject's data under this section. At any time during the maternal morbidity review process, the subject of the data may request in writing, using a form prescribed by the commissioner, that the commissioner remove the subject of the data's personal identifying information from data obtained by the commissioner under this section. The commissioner must comply with such requests. For purposes of this paragraph, "inform the subject of the data about the collection of the subject's data" means one notice sent by certified mail to the last known address of the subject of the data.

(d) The subject of the data may voluntarily participate in an informant interview with staff on behalf of the commissioner related to the maternal experience. If the subject of the data agrees to the interview, the commissioner may compensate the subject of the data for time and other expenses related to the interview.

(e) The commissioner may access Department of Human Services data to identify sources of care and services to assist with the evaluation of welfare systems to reduce preventable maternal morbidities.

Subd. 3. **Management of records.** After the commissioner has collected all data about a subject of a maternal morbidity study needed to perform the study, the data from source records obtained under subdivision 2, other than data identifying the subject, must be transferred to separate records to be maintained by the commissioner. Notwithstanding section 138.17, after the data has been transferred, all source records obtained under subdivision 2 possessed by the commissioner must be destroyed.

Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source records under subdivision 2, including identifying information on individual providers, data subjects, or their children, and data derived by the commissioner under subdivision 3 for the purpose of carrying out maternal morbidity studies, are classified as confidential data on individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3, and 13.10, subdivision 1, paragraph (a).

(b) Information classified under paragraph (a) shall not be subject to discovery or introduction into evidence in any administrative, civil, or criminal proceeding. Such information otherwise available from an original source shall not be immune from discovery or barred from introduction into evidence merely because it was utilized by the commissioner in carrying out maternal morbidity studies.

(c) Summary data on maternal morbidity studies created by the commissioner, which does not identify individual data subjects or individual providers, shall be public in accordance with section 13.05, subdivision 7.

(d) Data provided by the commissioner of human services to the commissioner of health under this section retains the same classification the data held when retained by the commissioner of human services, as required under section 13.03, subdivision 4, paragraph (c).

Sec. 63. Minnesota Statutes 2020, section 152.01, subdivision 23, is amended to read:

Subd. 23. **Analog.** (a) Except as provided in paragraph (b), "analog" means a substance, the chemical structure of which is substantially similar to the chemical structure of a controlled substance in Schedule I or II:

(1) that has a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance in Schedule I or II; or

(2) with respect to a particular person, if the person represents or intends that the substance have a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance in Schedule I or II.

(b) "Analog" does not include:

(1) a controlled substance;

(2) any substance for which there is an approved new drug application under the Federal Food, Drug, and Cosmetic Act; ~~or~~

(3) with respect to a particular person, any substance, if an exemption is in effect for investigational use, for that person, as provided by United States Code, title 21, section 355, and the person is registered as a controlled substance researcher as required under section 152.12, subdivision 3, to the extent conduct with respect to the substance is pursuant to the exemption and registration; or

(4) marijuana or tetrahydrocannabinols naturally contained in a plant of the genus cannabis or in the resinous extractives of the plant.

EFFECTIVE DATE. This section is effective August 1, 2021, and applies to crimes committed on or after that date.

Sec. 64. Minnesota Statutes 2020, section 152.02, subdivision 2, is amended to read:

Subd. 2. **Schedule I.** (a) Schedule I consists of the substances listed in this subdivision.

(b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the following substances, including their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the analogs, isomers, esters, ethers, and salts is possible:

(1) acetylmethadol;

(2) allylprodine;

(3) alphacetylmethadol (except levo-alphacetylmethadol, also known as levomethadyl acetate);

(4) alphameprodine;

(5) alphamethadol;

(6) alpha-methylfentanyl benzethidine;

(7) betacetylmethadol;

(8) betameprodine;

(9) betamethadol;

(10) betaprodine;

(11) clonitazene;

(12) dextromoramide;

(13) diampromide;

(14) diethyliambutene;

(15) difenoxin;

(16) dimenoxadol;

(17) dimepheptanol;

(18) dimethyliambutene;

(19) dioxaphetyl butyrate;

(20) dipipanone;

(21) ethylmethylthiambutene;

(22) etonitazene;

(23) etoxeridine;

(24) furethidine;

(25) hydroxypethidine;

(26) ketobemidone;

(27) levomoramide;

(28) levophenacylmorphan;

(29) 3-methylfentanyl;

(30) acetyl-alpha-methylfentanyl;

(31) alpha-methylthiofentanyl;

(32) benzylfentanyl beta-hydroxyfentanyl;

(33) beta-hydroxy-3-methylfentanyl;

(34) 3-methylthiofentanyl;

(35) thenylfentanyl;

(36) thiofentanyl;

(37) para-fluorofentanyl;

(38) morpheridine;

(39) 1-methyl-4-phenyl-4-propionoxypiperidine;

(40) noracymethadol;

(41) norlevorphanol;

(42) normethadone;

(43) norpipanone;

(44) 1-(2-phenylethyl)-4-phenyl-4-acetoxypiperidine (PEPAP);

(45) phenadoxone;

(46) phenampromide;

(47) phenomorphan;

(48) phenoperidine;

(49) piritramide;

(50) proheptazine;

(51) properidine;

(52) propiram;

(53) racemoramide;

(54) tilidine;

(55) trimeperidine;

(56) N-(1-Phenethylpiperidin-4-yl)-N-phenylacetamide (acetyl fentanyl);

(57) 3,4-dichloro-N-[(1R,2R)-2-(dimethylamino)cyclohexyl]-N-methylbenzamide(U47700);

(58) N-phenyl-N-[1-(2-phenylethyl)piperidin-4-yl]furan-2-carboxamide(furanylfentanyl);

(59) 4-(4-bromophenyl)-4-dimethylamino-1-phenethylcyclohexanol (bromadol);

(60) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide (Cyclopropryl fentanyl);

(61) N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide) (butyryl fentanyl);

(62) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine) (MT-45);

(63) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide (cyclopentyl fentanyl);

(64) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide (isobutyryl fentanyl);

(65) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide (valeryl fentanyl);

(66) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (para-chloroisobutyryl fentanyl);

(67) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-fluorobutyryl fentanyl);

(68) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-methoxybutyryl fentanyl);

(69) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide (ocfentanil);

(70) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (4-fluoroisobutyryl fentanyl or para-fluoroisobutyryl fentanyl);

(71) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide (acryl fentanyl or acryloylfentanyl);

(72) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide (methoxyacetyl fentanyl);

(73) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide (ortho-fluorofentanyl or 2-fluorofentanyl);

(74) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide (tetrahydrofuranyl fentanyl); and

(75) Fentanyl-related substances, their isomers, esters, ethers, salts and salts of isomers, esters and ethers, meaning any substance not otherwise listed under another federal Administration Controlled Substance Code Number or not otherwise listed in this section, and for which no exemption or approval is in effect under section 505 of the Federal Food, Drug, and Cosmetic Act, United States Code , title 21, section 355, that is structurally related to fentanyl by one or more of the following modifications:

(i) replacement of the phenyl portion of the phenethyl group by any monocycle, whether or not further substituted in or on the monocycle;

(ii) substitution in or on the phenethyl group with alkyl, alkenyl, alkoxyl, hydroxyl, halo, haloalkyl, amino, or nitro groups;

(iii) substitution in or on the piperidine ring with alkyl, alkenyl, alkoxyl, ester, ether, hydroxyl, halo, haloalkyl, amino, or nitro groups;

(iv) replacement of the aniline ring with any aromatic monocycle whether or not further substituted in or on the aromatic monocycle; or

(v) replacement of the N-propionyl group by another acyl group.

(c) Opium derivatives. Any of the following substances, their analogs, salts, isomers, and salts of isomers, unless specifically excepted or unless listed in another schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) acetorphine;

(2) acetyldihydrocodeine;

(3) benzylmorphine;

(4) codeine methylbromide;

(5) codeine-n-oxide;

(6) cyprenorphine;

(7) desomorphine;

(8) dihydromorphine;

(9) drotebanol;

(10) etorphine;

(11) heroin;

(12) hydromorphinol;

(13) methyldesorphine;

(14) methyldihydromorphine;

(15) morphine methylbromide;

(16) morphine methylsulfonate;

(17) morphine-n-oxide;

(18) myrophine;

(19) nicocodeine;

(20) nicomorphine;

(21) normorphine;

(22) pholcodine; and

(23) thebacon.

(d) Hallucinogens. Any material, compound, mixture or preparation which contains any quantity of the following substances, their analogs, salts, isomers (whether optical, positional, or geometric), and salts of isomers, unless specifically excepted or unless listed in another schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) methylenedioxy amphetamine;

(2) methylenedioxymethamphetamine;

(3) methylenedioxy-N-ethylamphetamine (MDEA);

(4) n-hydroxy-methylenedioxyamphetamine;

(5) 4-bromo-2,5-dimethoxyamphetamine (DOB);

(6) 2,5-dimethoxyamphetamine (2,5-DMA);

(7) 4-methoxyamphetamine;

(8) 5-methoxy-3, 4-methylenedioxyamphetamine;

(9) alpha-ethyltryptamine;

(10) bufotenine;

(11) diethyltryptamine;

(12) dimethyltryptamine;

(13) 3,4,5-trimethoxyamphetamine;

(14) 4-methyl-2, 5-dimethoxyamphetamine (DOM);

(15) ibogaine;

(16) lysergic acid diethylamide (LSD);

(17) mescaline;

(18) parahexyl;

(19) N-ethyl-3-piperidyl benzilate;

(20) N-methyl-3-piperidyl benzilate;

(21) psilocybin;

(22) psilocyn;

(23) tenocyclidine (TPCP or TCP);

(24) N-ethyl-1-phenyl-cyclohexylamine (PCE);

(25) 1-(1-phenylcyclohexyl) pyrrolidine (PCPy);

(26) 1-[1-(2-thienyl)cyclohexyl]-pyrrolidine (TCPy);

(27) 4-chloro-2,5-dimethoxyamphetamine (DOC);

(28) 4-ethyl-2,5-dimethoxyamphetamine (DOET);

(29) 4-iodo-2,5-dimethoxyamphetamine (DOI);

(30) 4-bromo-2,5-dimethoxyphenethylamine (2C-B);

(31) 4-chloro-2,5-dimethoxyphenethylamine (2C-C);

(32) 4-methyl-2,5-dimethoxyphenethylamine (2C-D);

(33) 4-ethyl-2,5-dimethoxyphenethylamine (2C-E);

(34) 4-iodo-2,5-dimethoxyphenethylamine (2C-I);

(35) 4-propyl-2,5-dimethoxyphenethylamine (2C-P);

(36) 4-isopropylthio-2,5-dimethoxyphenethylamine (2C-T-4);

(37) 4-propylthio-2,5-dimethoxyphenethylamine (2C-T-7);

(38) 2-(8-bromo-2,3,6,7-tetrahydrofuro [2,3-f][1]benzofuran-4-yl)ethanamine (2-CB-FLY);

(39) bromo-benzodifuranyl-isopropylamine (Bromo-DragonFLY);

(40) alpha-methyltryptamine (AMT);

(41) N,N-diisopropyltryptamine (DiPT);

(42) 4-acetoxy-N,N-dimethyltryptamine (4-AcO-DMT);

(43) 4-acetoxy-N,N-diethyltryptamine (4-AcO-DET);

(44) 4-hydroxy-N-methyl-N-propyltryptamine (4-HO-MPT);

(45) 4-hydroxy-N,N-dipropyltryptamine (4-HO-DPT);

(46) 4-hydroxy-N,N-diallyltryptamine (4-HO-DALT);

(47) 4-hydroxy-N,N-diisopropyltryptamine (4-HO-DiPT);

(48) 5-methoxy-N,N-diisopropyltryptamine (5-MeO-DiPT);

(49) 5-methoxy-α-methyltryptamine (5-MeO-AMT);

(50) 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT);

(51) 5-methylthio-N,N-dimethyltryptamine (5-MeS-DMT);

(52) 5-methoxy-N-methyl-N-isopropyltryptamine (5-MeO-MiPT);

(53) 5-methoxy-α-ethyltryptamine (5-MeO-AET);

(54) 5-methoxy-N,N-dipropyltryptamine (5-MeO-DPT);

(55) 5-methoxy-N,N-diethyltryptamine (5-MeO-DET);

(56) 5-methoxy-N,N-diallyltryptamine (5-MeO-DALT);

(57) methoxetamine (MXE);

(58) 5-iodo-2-aminoindane (5-IAI);

(59) 5,6-methylenedioxy-2-aminoindane (MDAI);

(60) 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe);

(61) 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe);

(62) 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe);

(63) 2-(2,5-Dimethoxyphenyl)ethanamine (2C-H);

(64) 2-(4-Ethylthio-2,5-dimethoxyphenyl)ethanamine (2C-T-2);

(65) N,N-Dipropyltryptamine (DPT);

(66) 3-[1-(Piperidin-1-yl)cyclohexyl]phenol (3-HO-PCP);

(67) N-ethyl-1-(3-methoxyphenyl)cyclohexanamine (3-MeO-PCE);

(68) 4-[1-(3-methoxyphenyl)cyclohexyl]morpholine (3-MeO-PCMo);

(69) 1-[1-(4-methoxyphenyl)cyclohexyl]-piperidine (methoxydine, 4-MeO-PCP);

(70) 2-(2-Chlorophenyl)-2-(ethylamino)cyclohexan-1-one (N-Ethylnorketamine, ethketamine, NENK);

(71) methylenedioxy-N,N-dimethylamphetamine (MDDMA);

(72) 3-(2-Ethyl(methyl)aminoethyl)-1H-indol-4-yl (4-AcO-MET); and

(73) 2-Phenyl-2-(methylamino)cyclohexanone (deschloroketamine).

(e) Peyote. All parts of the plant presently classified botanically as Lophophora williamsii Lemaire, whether growing or not, the seeds thereof, any extract from any part of the plant,

and every compound, manufacture, salts, derivative, mixture, or preparation of the plant, its seeds or extracts. The listing of peyote as a controlled substance in Schedule I does not apply to the nondrug use of peyote in bona fide religious ceremonies of the American Indian Church, and members of the American Indian Church are exempt from registration. Any person who manufactures peyote for or distributes peyote to the American Indian Church, however, is required to obtain federal registration annually and to comply with all other requirements of law.

(f) Central nervous system depressants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) mecloqualone;

(2) methaqualone;

(3) gamma-hydroxybutyric acid (GHB), including its esters and ethers;

(4) flunitrazepam;

(5) 2-(2-Methoxyphenyl)-2-(methylamino)cyclohexanone (2-MeO-2-deschloroketamine, methoxyketamine);

(6) tianeptine;

(7) clonazolam;

(8) etizolam;

(9) flubromazolam; and

(10) flubromazepam.

(g) Stimulants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

(1) aminorex;

(2) cathinone;

(3) fenethylline;

(4) methcathinone;

(5) methylaminorex;

(6) N,N-dimethylamphetamine;

(7) N-benzylpiperazine (BZP);

(8) methylmethcathinone (mephedrone);

(9) 3,4-methylenedioxy-N-methylcathinone (methylone);

(10) methoxymethcathinone (methedrone);

(11) methylenedioxypyrovalerone (MDPV);

(12) 3-fluoro-N-methylcathinone (3-FMC);

(13) methylethcathinone (MEC);

(14) 1-benzofuran-6-ylpropan-2-amine (6-APB);

(15) dimethylmethcathinone (DMMC);

(16) fluoroamphetamine;

(17) fluoromethamphetamine;

(18) α-methylaminobutyrophenone (MABP or buphedrone);

(19) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one (butylone);

(20) 2-(methylamino)-1-(4-methylphenyl)butan-1-one (4-MEMABP or BZ-6378);

(21) 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl) pentan-1-one (naphthylpyrovalerone or naphyrone);

(22) (alpha-pyrrolidinopentiophenone (alpha-PVP);

(23) (RS)-1-(4-methylphenyl)-2-(1-pyrrolidinyl)-1-hexanone (4-Me-PHP or MPHP);

(24) 2-(1-pyrrolidinyl)-hexanophenone (Alpha-PHP);

(25) 4-methyl-N-ethylcathinone (4-MEC);

(26) 4-methyl-alpha-pyrrolidinopropiophenone (4-MePPP);

(27) 2-(methylamino)-1-phenylpentan-1-one (pentedrone);

(28) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one (pentylone);

(29) 4-fluoro-N-methylcathinone (4-FMC);

(30) 3,4-methylenedioxy-N-ethylcathinone (ethylone);

(31) alpha-pyrrolidinobutiophenone (α-PBP);

(32) 5-(2-Aminopropyl)-2,3-dihydrobenzofuran (5-APDB);

(33) 1-phenyl-2-(1-pyrrolidinyl)-1-heptanone (PV8);

(34) 6-(2-Aminopropyl)-2,3-dihydrobenzofuran (6-APDB);

(35) 4-methyl-alpha-ethylaminopentiophenone (4-MEAPP);

(36) 4'-chloro-alpha-pyrrolidinopropiophenone (4'-chloro-PPP);

(37) 1-(1,3-Benzodioxol-5-yl)-2-(dimethylamino)butan-1-one (dibutylone, bk-DMBDB);

(38) 1-(3-chlorophenyl) piperazine (meta-chlorophenylpiperazine or mCPP);

(39) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one (N-ethylpentylone, ephylone); and

(40) any other substance, except bupropion or compounds listed under a different schedule, that is structurally derived from 2-aminopropan-1-one by substitution at the 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the compound is further modified in any of the following ways:

(i) by substitution in the ring system to any extent with alkyl, alkylenedioxy, alkoxy, haloalkyl, hydroxyl, or halide substituents, whether or not further substituted in the ring system by one or more other univalent substituents;

(ii) by substitution at the 3-position with an acyclic alkyl substituent;

(iii) by substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or methoxybenzyl groups; or

(iv) by inclusion of the 2-amino nitrogen atom in a cyclic structure.

(h) ~~Marijuana,~~ Synthetic tetrahydrocannabinols~~,~~ and synthetic cannabinoids. Unless specifically excepted or unless listed in another schedule, any ~~natural or~~ synthetic material, compound, mixture, or preparation that contains any quantity of the following substances, their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the isomers, esters, ethers, or salts is possible:

~~(1) marijuana;~~

~~(2)~~ (1) synthetic tetrahydrocannabinols ~~naturally contained in a plant of the genus Cannabis,~~ that are the synthetic equivalents of the substances contained in the cannabis plant or in the resinous extractives of the plant, or synthetic substances with similar chemical structure and pharmacological activity to those substances contained in the plant or resinous

extract, including, but not limited to, 1 cis or trans tetrahydrocannabinol, 6 cis or trans tetrahydrocannabinol, and 3,4 cis or trans tetrahydrocannabinol;

~~(3)~~ (2) synthetic cannabinoids, including the following substances:

(i) Naphthoylindoles, which are any compounds containing a 3-(1-napthoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of naphthoylindoles include, but are not limited to:

(A) 1-Pentyl-3-(1-naphthoyl)indole (JWH-018 and AM-678);

(B) 1-Butyl-3-(1-naphthoyl)indole (JWH-073);

(C) 1-Pentyl-3-(4-methoxy-1-naphthoyl)indole (JWH-081);

(D) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole (JWH-200);

(E) 1-Propyl-2-methyl-3-(1-naphthoyl)indole (JWH-015);

(F) 1-Hexyl-3-(1-naphthoyl)indole (JWH-019);

(G) 1-Pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);

(H) 1-Pentyl-3-(4-ethyl-1-naphthoyl)indole (JWH-210);

(I) 1-Pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);

(J) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM-2201).

(ii) Napthylmethylindoles, which are any compounds containing a 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent. Examples of naphthylmethylindoles include, but are not limited to:

(A) 1-Pentyl-1H-indol-3-yl-(1-naphthyl)methane (JWH-175);

(B) 1-Pentyl-1H-indol-3-yl-(4-methyl-1-naphthyl)methane (JWH-184).

(iii) Naphthoylpyrroles, which are any compounds containing a 3-(1-naphthoyl)pyrrole structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the pyrrole ring to any

extent, whether or not substituted in the naphthyl ring to any extent. Examples of naphthoylpyrroles include, but are not limited to, (5-(2-fluorophenyl)-1-pentylpyrrol-3-yl)-naphthalen-1-ylmethanone (JWH-307).

(iv) Naphthylmethylindenes, which are any compounds containing a naphthylideneindene structure with substitution at the 3-position of the indene ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indene ring to any extent, whether or not substituted in the naphthyl ring to any extent. Examples of naphthylemethylindenes include, but are not limited to, E-1-[1-(1-naphthalenylmethylene)-1H-inden-3-yl]pentane (JWH-176).

(v) Phenylacetylindoles, which are any compounds containing a 3-phenylacetylindole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent, whether or not substituted in the phenyl ring to any extent. Examples of phenylacetylindoles include, but are not limited to:

(A) 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole (RCS-8);

(B) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);

(C) 1-pentyl-3-(2-methylphenylacetyl)indole (JWH-251);

(D) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).

(vi) Cyclohexylphenols, which are compounds containing a 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not substituted in the cyclohexyl ring to any extent. Examples of cyclohexylphenols include, but are not limited to:

(A) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP 47,497);

(B) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (Cannabicyclohexanol or CP 47,497 C8 homologue);

(C) 5-(1,1-dimethylheptyl)-2-[(1R,2R)-5-hydroxy-2-(3-hydroxypropyl)cyclohexyl] -phenol (CP 55,940).

(vii) Benzoylindoles, which are any compounds containing a 3-(benzoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. Examples of benzoylindoles include, but are not limited to:

(A) 1-Pentyl-3-(4-methoxybenzoyl)indole (RCS-4);

(B) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM-694);

(C) (4-methoxyphenyl-[2-methyl-1-(2-(4-morpholinyl)ethyl)indol-3-yl]methanone (WIN 48,098 or Pravadoline).

(viii) Others specifically named:

(A) (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl) -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (HU-210);

(B) (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl) -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (Dexanabinol or HU-211);

(C) 2,3-dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de] -1,4-benzoxazin-6-yl-1-naphthalenylmethanone (WIN 55,212-2);

(D) (1-pentylindol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone (UR-144);

(E) (1-(5-fluoropentyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone (XLR-11);

(F) 1-pentyl-N-tricyclo[3.3.1.13,7]dec-1-yl-1H-indazole-3-carboxamide (AKB-48(APINACA));

(G) N-((3s,5s,7s)-adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide (5-Fluoro-AKB-48);

(H) 1-pentyl-8-quinolinyl ester-1H-indole-3-carboxylic acid (PB-22);

(I) 8-quinolinyl ester-1-(5-fluoropentyl)-1H-indole-3-carboxylic acid (5-Fluoro PB-22);

(J) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-pentyl-1H-indazole- 3-carboxamide (AB-PINACA);

(K) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(4-fluorophenyl)methyl]- 1H-indazole-3-carboxamide (AB-FUBINACA);

(L) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide(AB-CHMINACA);

(M) (S)-methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3- methylbutanoate (5-fluoro-AMB);

(N) [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl) methanone (THJ-2201);

(O) (1-(5-fluoropentyl)-1H-benzo[d]imidazol-2-yl)(naphthalen-1-yl)methanone) (FUBIMINA);

(P) (7-methoxy-1-(2-morpholinoethyl)-N-((1S,2S,4R)-1,3,3-trimethylbicyclo [2.2.1]heptan-2-yl)-1H-indole-3-carboxamide (MN-25 or UR-12);

(Q) (S)-N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl) -1H-indole-3-carboxamide (5-fluoro-ABICA);

(R) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl) -1H-indole-3-carboxamide;

(S) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl) -1H-indazole-3-carboxamide;

(T) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido) -3,3-dimethylbutanoate;

(U) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1(cyclohexylmethyl)-1 H-indazole-3-carboxamide (MAB-CHMINACA);

(V) N-(1-Amino-3,3-dimethyl-1-oxo-2-butanyl)-1-pentyl-1H-indazole-3-carboxamide (ADB-PINACA);

(W) methyl (1-(4-fluorobenzyl)-1H-indazole-3-carbonyl)-L-valinate (FUB-AMB);

(X) N-[(1S)-2-amino-2-oxo-1-(phenylmethyl)ethyl]-1-(cyclohexylmethyl)-1H-Indazole-3-carboxamide. (APP-CHMINACA);

(Y) quinolin-8-yl 1-(4-fluorobenzyl)-1H-indole-3-carboxylate (FUB-PB-22); and

(Z) methyl N-[1-(cyclohexylmethyl)-1H-indole-3-carbonyl]valinate (MMB-CHMICA).

(ix) Additional substances specifically named:

(A) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1 H-pyrrolo[2,3-B]pyridine-3-carboxamide (5F-CUMYL-P7AICA);

(B) 1-(4-cyanobutyl)-N-(2- phenylpropan-2-yl)-1 H-indazole-3-carboxamide (4-CN-Cumyl-Butinaca);

(C) naphthalen-1-yl-1-(5-fluoropentyl)-1-H-indole-3-carboxylate (NM2201; CBL2201);

(D) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1 H-indazole-3-carboxamide (5F-ABPINACA);

(E) methyl-2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate (MDMB CHMICA);

(F) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate (5F-ADB; 5F-MDMB-PINACA); and

(G) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl) 1H-indazole-3-carboxamide (ADB-FUBINACA).

(i) A controlled substance analog, to the extent that it is implicitly or explicitly intended for human consumption.

EFFECTIVE DATE. This section is effective August 1, 2021, and applies to crimes committed on or after that date.

Sec. 65. Minnesota Statutes 2020, section 152.02, subdivision 3, is amended to read:

Subd. 3. **Schedule II.** (a) Schedule II consists of the substances listed in this subdivision.

(b) Unless specifically excepted or unless listed in another schedule, any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate.

(i) Excluding:

(A) apomorphine;

(B) thebaine-derived butorphanol;

(C) dextrophan;

(D) nalbuphine;

(E) nalmefene;

(F) naloxegol;

(G) naloxone;

(H) naltrexone; and

(I) their respective salts;

(ii) but including the following:

(A) opium, in all forms and extracts;

(B) codeine;

(C) dihydroetorphine;

(D) ethylmorphine;

(E) etorphine hydrochloride;

(F) hydrocodone;

(G) hydromorphone;

(H) metopon;

(I) morphine;

(J) oxycodone;

(K) oxymorphone;

(L) thebaine;

(M) oripavine;

(2) any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in clause (1), except that these substances shall not include the isoquinoline alkaloids of opium;

(3) opium poppy and poppy straw;

(4) coca leaves and any salt, cocaine compound, derivative, or preparation of coca leaves (including cocaine and ecgonine and their salts, isomers, derivatives, and salts of isomers and derivatives), and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine;

(5) concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid, or powder form which contains the phenanthrene alkaloids of the opium poppy).

(c) Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters and ethers, unless specifically excepted, or unless listed in another schedule, whenever the existence of such isomers, esters, ethers and salts is possible within the specific chemical designation:

(1) alfentanil;

(2) alphaprodine;

(3) anileridine;

(4) bezitramide;

(5) bulk dextropropoxyphene (nondosage forms);

(6) carfentanil;

(7) dihydrocodeine;

(8) dihydromorphinone;

(9) diphenoxylate;

(10) fentanyl;

(11) isomethadone;

(12) levo-alpha-acetylmethadol (LAAM);

(13) levomethorphan;

(14) levorphanol;

(15) metazocine;

(16) methadone;

(17) methadone - intermediate, 4-cyano-2-dimethylamino-4, 4-diphenylbutane;

(18) moramide - intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic acid;

(19) pethidine;

(20) pethidine - intermediate - a, 4-cyano-1-methyl-4-phenylpiperidine;

(21) pethidine - intermediate - b, ethyl-4-phenylpiperidine-4-carboxylate;

(22) pethidine - intermediate - c, 1-methyl-4-phenylpiperidine-4-carboxylic acid;

(23) phenazocine;

(24) piminodine;

(25) racemethorphan;

(26) racemorphan;

(27) remifentanil;

(28) sufentanil;

(29) tapentadol;

(30) 4-Anilino-N-phenethylpiperidine.

(d) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

(1) amphetamine, its salts, optical isomers, and salts of its optical isomers;

(2) methamphetamine, its salts, isomers, and salts of its isomers;

(3) phenmetrazine and its salts;

(4) methylphenidate;

(5) lisdexamfetamine.

(e) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) amobarbital;

(2) glutethimide;

(3) secobarbital;

(4) pentobarbital;

(5) phencyclidine;

(6) phencyclidine immediate precursors:

(i) 1-phenylcyclohexylamine;

(ii) 1-piperidinocyclohexanecarbonitrile;

(7) phenylacetone.

(f) Cannabis and cannabinoids:

(1) nabilone;

(2) unless specifically excepted or unless listed in another schedule, any natural material, compound, mixture, or preparation that contains any quantity of the following substances, their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the isomers, esters, ethers, or salts is possible:

(i) marijuana; and

(ii) tetrahydrocannabinols naturally contained in a plant of the genus cannabis or in the resinous extractives of the plant; and

~~(2)~~ (3) dronabinol [(-)-delta-9-trans-tetrahydrocannabinol (delta-9-THC)] in an oral solution in a drug product approved for marketing by the United States Food and Drug Administration.

EFFECTIVE DATE. This section is effective August 1, 2021, and applies to crimes committed on or after that date.

Sec. 66. Minnesota Statutes 2020, section 152.11, subdivision 1a, is amended to read:

Subd. 1a. **Prescription requirements for Schedule II controlled substances.** Except as allowed under section 152.29, no person may dispense a controlled substance included in Schedule II of section 152.02 without a prescription issued by a doctor of medicine, a doctor of osteopathic medicine licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a doctor of podiatry, or a doctor of veterinary medicine, lawfully licensed to prescribe in this state or by a practitioner licensed to prescribe controlled substances by the state in which the prescription is issued, and having a current federal Drug Enforcement Administration registration number. The prescription must either be printed or written in ink and contain the handwritten signature of the prescriber or be transmitted electronically or by facsimile as permitted under subdivision 1. Provided that in emergency situations, as authorized by federal law, such drug may be dispensed upon oral prescription reduced promptly to writing and filed by the pharmacist. Such prescriptions shall be retained in conformity with section 152.101. No prescription for a Schedule II substance may be refilled.

Sec. 67. Minnesota Statutes 2020, section 152.11, is amended by adding a subdivision to read:

Subd. 5. **Exception.** References in this section to Schedule II controlled substances do not extend to marijuana or tetrahydrocannabinols.

Sec. 68. Minnesota Statutes 2020, section 152.12, is amended by adding a subdivision to read:

Subd. 6. **Exception.** References in this section to Schedule II controlled substances do not extend to marijuana or tetrahydrocannabinols.

Sec. 69. Minnesota Statutes 2020, section 152.125, subdivision 3, is amended to read:

Subd. 3. **Limits on applicability.** This section does not apply to:

(1) a physician's treatment of an individual for chemical dependency resulting from the use of controlled substances in Schedules II to V of section 152.02;

(2) the prescription or administration of controlled substances in Schedules II to V of section 152.02 to an individual whom the physician knows to be using the controlled substances for nontherapeutic purposes;

(3) the prescription or administration of controlled substances in Schedules II to V of section 152.02 for the purpose of terminating the life of an individual having intractable pain; ~~or~~

(4) the prescription or administration of a controlled substance in Schedules II to V of section 152.02 that is not a controlled substance approved by the United States Food and Drug Administration for pain relief; or

(5) the administration of medical cannabis under sections 152.22 to 152.37.

Sec. 70. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 5c. **Hemp processor.** "Hemp processor" means a person or business licensed by the commissioner of agriculture under chapter 18K to convert raw hemp into a product.

Sec. 71. Minnesota Statutes 2020, section 152.22, subdivision 6, is amended to read:

Subd. 6. **Medical cannabis.** (a) "Medical cannabis" means any species of the genus cannabis plant, or any mixture or preparation of them, including whole plant extracts and resins, and is delivered in the form of:

(1) liquid, including, but not limited to, oil;

(2) pill;

(3) vaporized delivery method with use of liquid or oil ~~but which does not require the use of dried leaves or plant form; or~~;

(4) combustion with use of dried raw cannabis; or

~~(4)~~ (5) any other method~~, excluding smoking,~~ approved by the commissioner.

(b) This definition includes any part of the genus cannabis plant prior to being processed into a form allowed under paragraph (a), that is possessed by a person while that person is engaged in employment duties necessary to carry out a requirement under sections 152.22 to 152.37 for a registered manufacturer or a laboratory under contract with a registered manufacturer. This definition also includes any hemp acquired by a manufacturer by a hemp grower as permitted under section 152.29, subdivision 1, paragraph (b).

EFFECTIVE DATE. This section is effective the earlier of (1) March 1, 2022, or (2) a date, as determined by the commissioner of health, by which (i) the rules adopted or amended under Minnesota Statutes, section 152.26, paragraph (b), are in effect and (ii) the independent laboratories under contract with the manufacturers have the necessary procedures and equipment in place to perform the required testing of dried raw cannabis. If this section is effective before March 1, 2022, the commissioner shall provide notice of that effective date to the public.

Sec. 72. Minnesota Statutes 2020, section 152.22, subdivision 11, is amended to read:

Subd. 11. **Registered designated caregiver.** "Registered designated caregiver" means a person who:

(1) is at least 18 years old;

(2) does not have a conviction for a disqualifying felony offense;

(3) has been approved by the commissioner to assist a patient who ~~has been identified by a health care practitioner as developmentally or physically disabled and therefore~~ requires

assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility ~~due to the disability~~; and

(4) is authorized by the commissioner to assist the patient with the use of medical cannabis.

Sec. 73. Minnesota Statutes 2020, section 152.23, is amended to read:

152.23 LIMITATIONS.

(a) Nothing in sections 152.22 to 152.37 permits any person to engage in and does not prevent the imposition of any civil, criminal, or other penalties for:

(1) undertaking any task under the influence of medical cannabis that would constitute negligence or professional malpractice;

(2) possessing or engaging in the use of medical cannabis:

(i) on a school bus or van;

(ii) on the grounds of any preschool or primary or secondary school;

(iii) in any correctional facility; or

(iv) on the grounds of any child care facility or home day care;

(3) vaporizing or combusting medical cannabis pursuant to section 152.22, subdivision 6:

(i) on any form of public transportation;

(ii) where the vapor would be inhaled by a nonpatient minor child or where the smoke would be inhaled by a minor child; or

(iii) in any public place, including any indoor or outdoor area used by or open to the general public or a place of employment as defined under section 144.413, subdivision 1b; and

(4) operating, navigating, or being in actual physical control of any motor vehicle, aircraft, train, or motorboat, or working on transportation property, equipment, or facilities while under the influence of medical cannabis.

(b) Nothing in sections 152.22 to 152.37 require the medical assistance and MinnesotaCare programs to reimburse an enrollee or a provider for costs associated with the medical use of cannabis. Medical assistance and MinnesotaCare shall continue to provide

coverage for all services related to treatment of an enrollee's qualifying medical condition if the service is covered under chapter 256B or 256L.

Sec. 74. Minnesota Statutes 2020, section 152.26, is amended to read:

152.26 RULEMAKING.

(a) The commissioner may adopt rules to implement sections 152.22 to 152.37. Rules for which notice is published in the State Register before January 1, 2015, may be adopted using the process in section 14.389.

(b) The commissioner may adopt or amend rules, using the procedure in section 14.386, paragraph (a), to implement the addition of dried raw cannabis as an allowable form of medical cannabis under section 152.22, subdivision 6, paragraph (a), clause (4). Section 14.386, paragraph (b) does not apply to these rules.

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

Sec. 75. Minnesota Statutes 2020, section 152.27, subdivision 3, is amended to read:

Subd. 3. **Patient application.** (a) The commissioner shall develop a patient application for enrollment into the registry program. The application shall be available to the patient and given to health care practitioners in the state who are eligible to serve as health care practitioners. The application must include:

(1) the name, mailing address, and date of birth of the patient;

(2) the name, mailing address, and telephone number of the patient's health care practitioner;

(3) the name, mailing address, and date of birth of the patient's designated caregiver, if any, or the patient's parent, legal guardian, or spouse if the parent, legal guardian, or spouse will be acting as a caregiver;

(4) a copy of the certification from the patient's health care practitioner that is dated within 90 days prior to submitting the application which certifies that the patient has been diagnosed with a qualifying medical condition ~~and, if applicable, that, in the health care practitioner's medical opinion, the patient is developmentally or physically disabled and, as a result of that disability, the patient requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility~~; and

(5) all other signed affidavits and enrollment forms required by the commissioner under sections 152.22 to 152.37, including, but not limited to, the disclosure form required under paragraph (c).

(b) The commissioner shall require a patient to resubmit a copy of the certification from the patient's health care practitioner on a yearly basis and shall require that the recertification be dated within 90 days of submission.

(c) The commissioner shall develop a disclosure form and require, as a condition of enrollment, all patients to sign a copy of the disclosure. The disclosure must include:

(1) a statement that, notwithstanding any law to the contrary, the commissioner, or an employee of any state agency, may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37; and

(2) the patient's acknowledgment that enrollment in the patient registry program is conditional on the patient's agreement to meet all of the requirements of sections 152.22 to 152.37.

Sec. 76. Minnesota Statutes 2020, section 152.27, subdivision 4, is amended to read:

Subd. 4. **Registered designated caregiver.** (a) The commissioner shall register a designated caregiver for a patient if ~~the patient's health care practitioner has certified that the patient, in the health care practitioner's medical opinion, is developmentally or physically disabled and, as a result of that disability,~~ the patient requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility and the caregiver has agreed, in writing, to be the patient's designated caregiver. As a condition of registration as a designated caregiver, the commissioner shall require the person to:

(1) be at least 18 years of age;

(2) agree to only possess the patient's medical cannabis for purposes of assisting the patient; and

(3) agree that if the application is approved, the person will not be a registered designated caregiver for more than ~~one patient, unless the~~ six registered patients at one time. Patients who reside in the same residence shall count as one patient.

(b) The commissioner shall conduct a criminal background check on the designated caregiver prior to registration to ensure that the person does not have a conviction for a disqualifying felony offense. Any cost of the background check shall be paid by the person

seeking registration as a designated caregiver. A designated caregiver must have the criminal background check renewed every two years.

(c) Nothing in sections 152.22 to 152.37 shall be construed to prevent a person registered as a designated caregiver from also being enrolled in the registry program as a patient and possessing and using medical cannabis as a patient.

Sec. 77. Minnesota Statutes 2020, section 152.27, subdivision 6, is amended to read:

Subd. 6. **Patient enrollment.** (a) After receipt of a patient's application, application fees, and signed disclosure, the commissioner shall enroll the patient in the registry program and issue the patient and patient's registered designated caregiver or parent, legal guardian, or spouse, if applicable, a registry verification. The commissioner shall approve or deny a patient's application for participation in the registry program within 30 days after the commissioner receives the patient's application and application fee. ~~The commissioner may approve applications up to 60 days after the receipt of a patient's application and application fees until January 1, 2016.~~ A patient's enrollment in the registry program shall only be denied if the patient:

(1) does not have certification from a health care practitioner that the patient has been diagnosed with a qualifying medical condition;

(2) has not signed and returned the disclosure form required under subdivision 3, paragraph (c), to the commissioner;

(3) does not provide the information required; or

~~(4) has previously been removed from the registry program for violations of section 152.30 or 152.33; or~~

~~(5)~~ (4) provides false information.

(b) The commissioner shall give written notice to a patient of the reason for denying enrollment in the registry program.

(c) Denial of enrollment into the registry program is considered a final decision of the commissioner and is subject to judicial review under the Administrative Procedure Act pursuant to chapter 14.

(d) A patient's enrollment in the registry program may only be revoked upon the death of the patient or if a patient violates a requirement under section 152.30 or 152.33. If a patient's enrollment in the registry program has been revoked due to a violation of section 152.30 or 152.33, the patient may reapply for enrollment 12 months from the date the

patient's enrollment was revoked. The commissioner shall process the application in accordance with this section.

(e) The commissioner shall develop a registry verification ~~to provide to the patient, the health care practitioner identified in the patient's application, and to the manufacturer~~ system for health care practitioners identified in the patient's application and for manufacturers. The registry verification system shall include:

(1) the patient's name and date of birth;

(2) the patient registry number assigned to the patient; and

(3) the name and date of birth of the patient's registered designated caregiver, if any, or the name of the patient's parent, legal guardian, or spouse if the parent, legal guardian, or spouse will be acting as a caregiver.

Sec. 78. Minnesota Statutes 2020, section 152.28, subdivision 1, is amended to read:

Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in the registry program, a health care practitioner shall:

(1) determine, in the health care practitioner's medical judgment, whether a patient suffers from a qualifying medical condition, and, if so determined, provide the patient with a certification of that diagnosis;

(2) ~~determine whether a patient is developmentally or physically disabled and, as a result of that disability, the patient requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility, and, if so determined, include that determination on the patient's certification of diagnosis;~~

~~(3)~~ advise patients, registered designated caregivers, and parents, legal guardians, or spouses who are acting as caregivers of the existence of any nonprofit patient support groups or organizations;

~~(4)~~ (3) provide explanatory information from the commissioner to patients with qualifying medical conditions, including disclosure to all patients about the experimental nature of therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the proposed treatment; the application and other materials from the commissioner; and provide patients with the Tennessen warning as required by section 13.04, subdivision 2; and

~~(5)~~ (4) agree to continue treatment of the patient's qualifying medical condition and report medical findings to the commissioner.

(b) Upon notification from the commissioner of the patient's enrollment in the registry program, the health care practitioner shall:

(1) participate in the patient registry reporting system under the guidance and supervision of the commissioner;

(2) report health records of the patient throughout the ongoing treatment of the patient to the commissioner in a manner determined by the commissioner and in accordance with subdivision 2;

(3) determine, on a yearly basis, if the patient continues to suffer from a qualifying medical condition and, if so, issue the patient a new certification of that diagnosis; and

(4) otherwise comply with all requirements developed by the commissioner.

(c) A health care practitioner may conduct a patient assessment to issue a recertification as required under paragraph (b), clause (3), via telemedicine as defined under section 62A.671, subdivision 9.

(d) Nothing in this section requires a health care practitioner to participate in the registry program.

Sec. 79. Minnesota Statutes 2020, section 152.29, subdivision 1, is amended to read:

Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer may operate eight distribution facilities, which may include the manufacturer's single location for cultivation, harvesting, manufacturing, packaging, and processing but is not required to include that location. The commissioner shall designate the geographical service areas to be served by each manufacturer based on geographical need throughout the state to improve patient access. A manufacturer shall not have more than two distribution facilities in each geographical service area assigned to the manufacturer by the commissioner. A manufacturer shall operate only one location where all cultivation, harvesting, manufacturing, packaging, and processing of medical cannabis shall be conducted. This location may be one of the manufacturer's distribution facility sites. The additional distribution facilities may dispense medical cannabis and medical cannabis products but may not contain any medical cannabis in a form other than those forms allowed under section 152.22, subdivision 6, and the manufacturer shall not conduct any cultivation, harvesting, manufacturing, packaging, or processing at the other distribution facility sites. Any distribution facility operated by the manufacturer is subject to all of the requirements applying to the manufacturer under sections 152.22 to 152.37, including, but not limited to, security and distribution requirements.

(b) A manufacturer may acquire hemp grown in this state from a hemp grower, and may acquire hemp products produced by a hemp processor. A manufacturer may manufacture or process hemp and hemp products into an allowable form of medical cannabis under section 152.22, subdivision 6. Hemp and hemp products acquired by a manufacturer under this paragraph ~~is~~ are subject to the same quality control program, security and testing requirements, and other requirements that apply to medical cannabis under sections 152.22 to 152.37 and Minnesota Rules, chapter 4770.

(c) A medical cannabis manufacturer shall contract with a laboratory approved by the commissioner, subject to any additional requirements set by the commissioner, for purposes of testing medical cannabis manufactured or hemp or hemp products acquired by the medical cannabis manufacturer as to content, contamination, and consistency to verify the medical cannabis meets the requirements of section 152.22, subdivision 6. The cost of laboratory testing shall be paid by the manufacturer.

(d) The operating documents of a manufacturer must include:

(1) procedures for the oversight of the manufacturer and procedures to ensure accurate record keeping;

(2) procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabis and unauthorized entrance into areas containing medical cannabis; and

(3) procedures for the delivery and transportation of hemp between hemp growers and manufacturers and for the delivery and transportation of hemp products between hemp processors and manufacturers.

(e) A manufacturer shall implement security requirements, including requirements for the delivery and transportation of hemp and hemp products, protection of each location by a fully operational security alarm system, facility access controls, perimeter intrusion detection systems, and a personnel identification system.

(f) A manufacturer shall not share office space with, refer patients to a health care practitioner, or have any financial relationship with a health care practitioner.

(g) A manufacturer shall not permit any person to consume medical cannabis on the property of the manufacturer.

(h) A manufacturer is subject to reasonable inspection by the commissioner.

(i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is not subject to the Board of Pharmacy licensure or regulatory requirements under chapter 151.

(j) A medical cannabis manufacturer may not employ any person who is under 21 years of age or who has been convicted of a disqualifying felony offense. An employee of a medical cannabis manufacturer must submit a completed criminal history records check consent form, a full set of classifiable fingerprints, and the required fees for submission to the Bureau of Criminal Apprehension before an employee may begin working with the manufacturer. The bureau must conduct a Minnesota criminal history records check and the superintendent is authorized to exchange the fingerprints with the Federal Bureau of Investigation to obtain the applicant's national criminal history record information. The bureau shall return the results of the Minnesota and federal criminal history records checks to the commissioner.

(k) A manufacturer may not operate in any location, whether for distribution or cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a public or private school existing before the date of the manufacturer's registration with the commissioner.

(l) A manufacturer shall comply with reasonable restrictions set by the commissioner relating to signage, marketing, display, and advertising of medical cannabis.

(m) Before a manufacturer acquires hemp from a hemp grower or hemp products from a hemp processor, the manufacturer must verify that the hemp grower or hemp processor has a valid license issued by the commissioner of agriculture under chapter 18K.

(n) Until a state-centralized, seed-to-sale system is implemented that can track a specific medical cannabis plant from cultivation through testing and point of sale, the commissioner shall conduct at least one unannounced inspection per year of each manufacturer that includes inspection of:

(1) business operations;

(2) physical locations of the manufacturer's manufacturing facility and distribution facilities;

(3) financial information and inventory documentation, including laboratory testing results; and

(4) physical and electronic security alarm systems.

Sec. 80. Minnesota Statutes 2020, section 152.29, subdivision 3, is amended to read:

Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval

for the distribution of medical cannabis to a patient. A manufacturer may transport medical cannabis or medical cannabis products that have been cultivated, harvested, manufactured, packaged, and processed by that manufacturer to another registered manufacturer for the other manufacturer to distribute.

(b) A manufacturer may distribute medical cannabis products, whether or not the products have been manufactured by that manufacturer.

(c) Prior to distribution of any medical cannabis, the manufacturer shall:

(1) verify that the manufacturer has received the registry verification from the commissioner for that individual patient;

(2) verify that the person requesting the distribution of medical cannabis is the patient, the patient's registered designated caregiver, or the patient's parent, legal guardian, or spouse listed in the registry verification using the procedures described in section 152.11, subdivision 2d;

(3) assign a tracking number to any medical cannabis distributed from the manufacturer;

(4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to chapter 151 has consulted with the patient to determine the proper dosage for the individual patient after reviewing the ranges of chemical compositions of the medical cannabis and the ranges of proper dosages reported by the commissioner. For purposes of this clause, a consultation may be conducted remotely ~~using a~~ by secure videoconference, telephone, or other remote means, so long as the employee providing the consultation is able to confirm the identity of the patient~~, the consultation occurs while the patient is at a distribution facility,~~ and the consultation adheres to patient privacy requirements that apply to health care services delivered through telemedicine. A pharmacist consultation under this clause is not required when a manufacturer is distributing medical cannabis to a patient according to a patient-specific dosage plan established with that manufacturer and is not modifying the dosage or product being distributed under that plan and the medical cannabis is distributed by a pharmacy technician;

(5) properly package medical cannabis in compliance with the United States Poison Prevention Packing Act regarding child-resistant packaging and exemptions for packaging for elderly patients, and label distributed medical cannabis with a list of all active ingredients and individually identifying information, including:

(i) the patient's name and date of birth;

(ii) the name and date of birth of the patient's registered designated caregiver or, if listed on the registry verification, the name of the patient's parent or legal guardian, if applicable;

(iii) the patient's registry identification number;

(iv) the chemical composition of the medical cannabis; and

(v) the dosage; and

(6) ensure that the medical cannabis distributed contains a maximum of a 90-day supply of the dosage determined for that patient.

(d) A manufacturer shall require any employee of the manufacturer who is transporting medical cannabis or medical cannabis products to a distribution facility or to another registered manufacturer to carry identification showing that the person is an employee of the manufacturer.

(e) A manufacturer shall distribute medical cannabis in dried raw cannabis form only to a patient age 21 or older, or to the registered designated caregiver, parent, legal guardian, or spouse of a patient age 21 or older.

EFFECTIVE DATE. Paragraph (e) is effective the earlier of (1) March 1, 2022, or (2) a date, as determined by the commissioner of health, by which (i) the rules adopted or amended under Minnesota Statutes, section 152.26, paragraph (b), are in effect and (ii) the independent laboratories under contract with the manufacturers have the necessary procedures and equipment in place to perform the required testing of dried raw cannabis. If this section is effective before March 1, 2022, the commissioner shall provide notice of that effective date to the public.

Sec. 81. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to read:

Subd. 3b. **Distribution to recipient in a motor vehicle.** A manufacturer may distribute medical cannabis to a patient, registered designated caregiver, or parent, legal guardian, or spouse of a patient who is at the distribution facility but remains in a motor vehicle, provided:

(1) distribution facility staff receive payment and distribute medical cannabis in a designated zone that is as close as feasible to the front door of the distribution facility;

(2) the manufacturer ensures that the receipt of payment and distribution of medical cannabis are visually recorded by a closed-circuit television surveillance camera at the distribution facility and provides any other necessary security safeguards;

(3) the manufacturer does not store medical cannabis outside a restricted access area at the distribution facility, and distribution facility staff transport medical cannabis from a restricted access area at the distribution facility to the designated zone for distribution only after confirming that the patient, designated caregiver, or parent, guardian, or spouse has arrived in the designated zone;

(4) the payment and distribution of medical cannabis take place only after a pharmacist consultation takes place, if required under subdivision 3, paragraph (c), clause (4);

(5) immediately following distribution of medical cannabis, distribution facility staff enter the transaction in the state medical cannabis registry information technology database; and

(6) immediately following distribution of medical cannabis, distribution facility staff take the payment received into the distribution facility.

Sec. 82. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to read:

Subd. 3c. **Disposal of medical cannabis plant root balls.** Notwithstanding Minnesota Rules, part 4770.1200, subpart 2, item C, a manufacturer is not required to grind root balls of medical cannabis plants or incorporate them with a greater quantity of nonconsumable solid waste before transporting root balls to another location for disposal. For purposes of this subdivision, "root ball" means a compact mass of roots formed by a plant and any attached growing medium.

Sec. 83. Minnesota Statutes 2020, section 152.31, is amended to read:

152.31 DATA PRACTICES.

(a) Government data in patient files maintained by the commissioner and the health care practitioner, and data submitted to or by a medical cannabis manufacturer, are private data on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in section 13.02, subdivision 9, but may be used for purposes of complying with chapter 13 and complying with a request from the legislative auditor or the state auditor in the performance of official duties. The provisions of section 13.05, subdivision 11, apply to a registration agreement entered between the commissioner and a medical cannabis manufacturer under section 152.25.

(b) Not public data maintained by the commissioner may not be used for any purpose not provided for in sections 152.22 to 152.37, and may not be combined or linked in any manner with any other list, dataset, or database.

(c) The commissioner may execute data sharing arrangements with the commissioner of agriculture to verify licensing, inspection, and compliance information related to hemp growers and hemp processors under chapter 18K.

Sec. 84. Minnesota Statutes 2020, section 171.07, is amended by adding a subdivision to read:

Subd. 3b. **Identification card for homeless youth.** (a) A homeless youth, as defined in section 256K.45, subdivision 1a, who meets the requirements of this subdivision may obtain a noncompliant identification card, notwithstanding section 171.06, subdivision 3.

(b) An applicant under this subdivision must:

(1) provide the applicant's full name, date of birth, and sex;

(2) provide the applicant's height in feet and inches, weight in pounds, and eye color;

(3) submit a certified copy of a birth certificate issued by a government bureau of vital statistics or equivalent agency in the applicant's state of birth, which must bear the raised or authorized seal of the issuing government entity; and

(4) submit a statement verifying that the applicant is a homeless youth who resides in Minnesota that is signed by:

(i) an employee of a human services agency receiving public funding to provide services to homeless youth, runaway youth, youth with mental illness, or youth with substance use disorders; or

(ii) staff at a school who provide services to homeless youth or a school social worker.

(c) For a noncompliant identification card under this subdivision:

(1) the commissioner must not impose a fee, surcharge, or filing fee under section 171.06, subdivision 2; and

(2) a driver's license agent must not impose a filing fee under section 171.061, subdivision 4.

(d) Minnesota Rules, parts 7410.0400 and 7410.0410, or successor rules, do not apply for an identification card under this subdivision.

EFFECTIVE DATE. This section is effective the day following final enactment for application and issuance of Minnesota identification cards on and after January 1, 2022.

Sec. 85. Minnesota Statutes 2020, section 256.98, subdivision 1, is amended to read:

Subdivision 1. **Wrongfully obtaining assistance.** (a) A person who commits any of the following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897, the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program formerly codified in sections 256.72 to 256.871, chapter 256B, 256D, 256I, 256J, 256K, or 256L, child care assistance programs, and emergency assistance programs under section 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses (1) to (5):

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of any material fact, or by impersonation or other fraudulent device, assistance or the continued receipt of assistance, to include child care assistance or ~~vouchers~~ food benefits produced according to sections 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365, 256.94, and 256L.01 to 256L.15, to which the person is not entitled or assistance greater than that to which the person is entitled;

(2) knowingly aids or abets in buying or in any way disposing of the property of a recipient or applicant of assistance without the consent of the county agency; or

(3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments to which the individual is not entitled as a provider of subsidized child care, or by furnishing or concurring in a willfully false claim for child care assistance.

(b) The continued receipt of assistance to which the person is not entitled or greater than that to which the person is entitled as a result of any of the acts, failure to act, or concealment described in this subdivision shall be deemed to be continuing offenses from the date that the first act or failure to act occurred.

Sec. 86. Minnesota Statutes 2020, section 256B.0625, subdivision 52, is amended to read:

Subd. 52. **Lead risk assessments.** (a) Effective October 1, 2007, or six months after federal approval, whichever is later, medical assistance covers lead risk assessments provided by a lead risk assessor who is licensed by the commissioner of health under section 144.9505 and employed by an assessing agency as defined in section 144.9501. Medical assistance covers a onetime on-site investigation of a recipient's home or primary residence to determine

the existence of lead so long as the recipient is under the age of 21 and has a venous blood lead level specified in section 144.9504, subdivision 2, paragraph ~~(a)~~ (b).

(b) Medical assistance reimbursement covers the lead risk assessor's time to complete the following activities:

(1) gathering samples;

(2) interviewing family members;

(3) gathering data, including meter readings; and

(4) providing a report with the results of the investigation and options for reducing lead-based paint hazards.

Medical assistance coverage of lead risk assessment does not include testing of environmental substances such as water, paint, or soil or any other laboratory services. Medical assistance coverage of lead risk assessments is not included in the capitated services for children enrolled in health plans through the prepaid medical assistance program and the MinnesotaCare program.

(c) Payment for lead risk assessment must be cost-based and must meet the criteria for federal financial participation under the Medicaid program. The rate must be based on allowable expenditures from cost information gathered. Under section 144.9507, subdivision 5, federal medical assistance funds may not replace existing funding for lead-related activities. The nonfederal share of costs for services provided under this subdivision must be from state or local funds and is the responsibility of the agency providing the risk assessment. When the risk assessment is conducted by the commissioner of health, the state share must be from appropriations to the commissioner of health for this purpose. Eligible expenditures for the nonfederal share of costs may not be made from federal funds or funds used to match other federal funds. Any federal disallowances are the responsibility of the agency providing risk assessment services.

Sec. 87. Minnesota Statutes 2020, section 326.71, subdivision 4, is amended to read:

Subd. 4. **Asbestos-related work.** "Asbestos-related work" means the enclosure, removal, or encapsulation of asbestos-containing material in a quantity that meets or exceeds 260 linear feet of friable asbestos-containing material on pipes, 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, a total of 35 cubic feet of friable asbestos-containing material on or off all facility components in one facility. In the case of single or multifamily residences, "asbestos-related work" also means the enclosure, removal, or encapsulation of greater than

ten but less than 260 linear feet of friable asbestos-containing material on pipes, greater than six but less than 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, greater than one cubic foot but less than 35 cubic feet of friable asbestos-containing material on or off all facility components in one facility. ~~This provision excludes asbestos-containing floor tiles and sheeting, roofing materials, siding, and all ceilings with asbestos-containing material in single family residences and buildings with no more than four dwelling units.~~ Asbestos-related work includes asbestos abatement area preparation; enclosure, removal, or encapsulation operations; and an air quality monitoring specified in rule to assure that the abatement and adjacent areas are not contaminated with asbestos fibers during the project and after completion.

For purposes of this subdivision, the quantity of ~~asbestos containing~~ material applies separately for every project.

Sec. 88. Minnesota Statutes 2020, section 326.75, subdivision 1, is amended to read:

Subdivision 1. **Licensing fee.** A person required to be licensed under section 326.72 shall, before receipt of the license and before causing asbestos-related work to be performed, pay the commissioner an annual license fee of ~~$100~~ $105.

Sec. 89. Minnesota Statutes 2020, section 326.75, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** An individual required to be certified as an asbestos worker or asbestos site supervisor under section 326.73, subdivision 1, shall pay the commissioner a certification fee of ~~$50~~ $52.50 before the issuance of the certificate. ~~The commissioner may establish by rule fees required before the issuance of~~ An individual required to be certified as an asbestos inspector, asbestos management planner, and asbestos project designer ~~certificates required~~ under section 326.73, subdivisions 2, 3, and 4, shall pay the commissioner a certification fee of $105 before the issuance of the certificate.

Sec. 90. Minnesota Statutes 2020, section 326.75, subdivision 3, is amended to read:

Subd. 3. **Permit fee.** Five calendar days before beginning asbestos-related work, a person shall pay a project permit fee to the commissioner equal to ~~one~~ two percent of the total costs of the asbestos-related work. For asbestos-related work performed in single or multifamily residences, of greater than ten but less than 260 linear feet of asbestos-containing material on pipes, or greater than six but less than 160 square feet of asbestos-containing material

on other facility components, a person shall pay a project permit fee of $35 to the commissioner.

Sec. 91. Laws 2020, Seventh Special Session chapter 1, article 6, section 12, subdivision 4, is amended to read:

Subd. 4. **Housing with services establishment registration; conversion to an assisted living facility license.** (a) Housing with services establishments registered under chapter 144D, providing home care services according to chapter 144A to at least one resident, and intending to provide assisted living services on or after August 1, 2021, must submit an application for an assisted living facility license in accordance with section 144G.12 no later than June 1, 2021. The commissioner shall consider the application in accordance with section ~~144G.16~~ 144G.15.

(b) Notwithstanding the housing with services contract requirements identified in section 144D.04, any existing housing with services establishment registered under chapter 144D that does not intend to convert its registration to an assisted living facility license under this chapter must provide written notice to its residents at least 60 days before the expiration of its registration, or no later than May 31, 2021, whichever is earlier. The notice must:

(1) state that the housing with services establishment does not intend to convert to an assisted living facility;

(2) include the date when the housing with services establishment will no longer provide housing with services;

(3) include the name, e-mail address, and phone number of the individual associated with the housing with services establishment that the recipient of home care services may contact to discuss the notice;

(4) include the contact information consisting of the phone number, e-mail address, mailing address, and website for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and

(5) for residents who receive home and community-based waiver services under section 256B.49 and chapter 256S, also be provided to the resident's case manager at the same time that it is provided to the resident.

(c) A housing with services registrant that obtains an assisted living facility license, but does so under a different business name as a result of reincorporation, and continues to provide services to the recipient, is not subject to the 60-day notice required under paragraph

(b). However, the provider must otherwise provide notice to the recipient as required under sections 144D.04 and 144D.045, as applicable, and section 144D.09.

(d) All registered housing with services establishments providing assisted living under sections 144G.01 to 144G.07 prior to August 1, 2021, must have an assisted living facility license under this chapter.

(e) Effective August 1, 2021, any housing with services establishment registered under chapter 144D that has not converted its registration to an assisted living facility license under this chapter is prohibited from providing assisted living services.

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

Sec. 92. **ADDITIONAL MEMBER TO COVID-19 VACCINE ALLOCATION ADVISORY GROUP.**

The commissioner of health shall appoint an individual who is an expert on vaccine disinformation to the state COVID-19 Vaccine Allocation Advisory Group no later than .....

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

Sec. 93. **FEDERAL SCHEDULE I EXEMPTION APPLICATION FOR MEDICAL USE OF CANNABIS.**

By September 1, 2021, the commissioner of health shall apply to the Drug Enforcement Administration's Office of Diversion Control for an exception under Code of Federal Regulations, title 21, section 1307.03, and request formal written acknowledgment that the listing of marijuana, marijuana extract, and tetrahydrocannabinols as controlled substances in federal Schedule I does not apply to the protected activities in Minnesota Statutes, section 152.32, subdivision 2, pursuant to the medical cannabis program established under Minnesota Statutes, sections 152.22 to 152.37. The application shall include the list of presumptions in Minnesota Statutes, section 152.32, subdivision 1.

Sec. 94. **RECOMMENDATIONS; EXPANDED ACCESS TO DATA FROM ALL-PAYER CLAIMS DATABASE.**

The commissioner of health shall develop recommendations to expand access to data in the all-payer claims database under Minnesota Statutes, section 62U.04, to additional outside entities for public health or research purposes. In the recommendations, the commissioner must address an application process for outside entities to access the data,

how the department will exercise ongoing oversight over data use by outside entities, purposes for which the data may be used by outside entities, establishment of a data access committee to advise the department on selecting outside entities that may access the data, and steps outside entities must take to protect data held by those entities from unauthorized use. Following development of these recommendations, an outside entity that accesses data in compliance with these recommendations may publish results that identify hospitals, clinics, and medical practices so long as no individual health professionals are identified and the commissioner finds the data to be accurate, valid, and suitable for publication for such use. The commissioner shall submit these recommendations by December 15, 2021, to the chairs and ranking minority members of the legislative committees with jurisdiction over health policy and civil law.

Sec. 95. **SKIN LIGHTENING PRODUCTS PUBLIC AWARENESS AND EDUCATION GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a grant program for the purpose of increasing public awareness and education on the health dangers associated with using skin lightening creams and products that contain mercury that are manufactured in other countries and brought into this country and sold illegally online or in stores.

Subd. 2. **Grants authorized.** The commissioner shall award grants through a request for proposal process to community-based, nonprofit organizations that serve ethnic communities and that focus on public health outreach to Black, Indigenous, and people of color communities on the issue of skin lightening products and chemical exposure from these products. Priority in awarding grants shall be given to organizations that have historically provided services to ethnic communities on the skin lightening and chemical exposure issue for the past three years.

Subd. 3. **Grant allocation.** (a) Grantees must use the funds to conduct public awareness and education activities that are culturally specific and community-based and focus on:

(1) the dangers of exposure to mercury through dermal absorption, inhalation, hand-to-mouth contact, and through contact with individuals who have used these skin lightening products;

(2) the signs and symptoms of mercury poisoning;

(3) the health effects of mercury poisoning, including the permanent effects on the central nervous system and kidneys;

(4) the dangers of using these products or being exposed to these products during pregnancy and breastfeeding to the mother and to the infant;

(5) knowing how to identify products that contain mercury; and

(6) proper disposal of the product if the product contains mercury.

(b) The grant application must include:

(1) a description of the purpose or project for which the grant funds will be used;

(2) a description of the objectives, a work plan, and a timeline for implementation; and

(3) the community or group the grant proposes to focus on.

Sec. 96. **TRAUMA-INFORMED GUN VIOLENCE REDUCTION; PILOT PROGRAM.**

Subdivision 1. **Pilot program.** (a) The commissioner of health shall establish a pilot program to aid in the reduction of trauma resulting from gun violence and address the root causes of gun violence by making the following resources available to professionals and organizations in health care, public health, mental health, social service, law enforcement, and victim advocacy and other professionals who are most likely to encounter individuals who have been victims, witnesses, or perpetrators of gun violence occurring in a community, or in a domestic or other setting:

(1) training on recognizing trauma as both a result and a cause of gun violence;

(2) developing skills to address the effects of trauma on individuals and family members;

(3) investments in community-based organizations to enable high-quality, targeted services to individuals in need. This may include resources for additional training, hiring of specialized staff needed to address trauma-related issues, management information systems to facilitate data collection, and expansion of existing programming;

(4) replication and expansion of effective community-based gun violence prevention initiatives, such as Project Life, the Minneapolis Group Violence Intervention initiative, to connect at-risk individuals to mental health services, job readiness programs, and employment opportunities; and

(5) education campaigns and outreach materials to educate communities, organizations, and the public about the relationship between trauma and gun violence.

(b) The pilot program shall address the traumatic effects of gun violence exposure using a holistic treatment modality.

Subd. 2. **Program guidelines and protocols.** (a) The commissioner, with advice from an advisory panel knowledgeable about gun violence and its traumatic impact, shall develop protocols and program guidelines that address resources and training to be used by professionals who encounter individuals who have perpetrated or been impacted by gun violence. Educational, training, and outreach material must be culturally appropriate for the community and provided in multiple languages for those with limited English language proficiency. The materials developed must address necessary responses by local, state, and other governmental entities tasked with addressing gun violence. The protocols must include a method of informing affected communities and local governments representing those communities on effective strategies to target community, domestic, and other forms of gun violence.

(b) The commissioner may enter into contractual agreements with community-based organizations or experts in the field to perform any of the activities under this section.

Subd. 3. **Report.** By November 15, 2021, the commissioner shall submit a report on the progress of the pilot program to the chairs and ranking minority members of the committees with jurisdiction over health and public safety.

Sec. 97. **REVISOR INSTRUCTION.**

The revisor of statutes shall amend the section headnote for Minnesota Statutes, section 62J.63, to read "HEALTH CARE PURCHASING AND PERFORMANCE MEASUREMENT".

Sec. 98. **REPEALER.**

Minnesota Statutes 2020, sections 62J.63, subdivision 3; 144.0721, subdivision 1; 144.0722; 144.0724, subdivision 10; and 144.693, are repealed.

ARTICLE 4
HEALTH-RELATED LICENSING BOARDS

Section 1. Minnesota Statutes 2020, section 156.12, subdivision 2, is amended to read:

Subd. 2. **Authorized activities.** No provision of this chapter shall be construed to prohibit:

(a) a person from rendering necessary gratuitous assistance in the treatment of any animal when the assistance does not amount to prescribing, testing for, or diagnosing, operating, or vaccinating and when the attendance of a licensed veterinarian cannot be procured;

(b) a person who is a regular student in an accredited or approved college of veterinary medicine from performing duties or actions assigned by instructors or preceptors or working under the direct supervision of a licensed veterinarian;

(c) a veterinarian regularly licensed in another jurisdiction from consulting with a licensed veterinarian in this state;

(d) the owner of an animal and the owner's regular employee from caring for and administering to the animal belonging to the owner, except where the ownership of the animal was transferred for purposes of circumventing this chapter;

(e) veterinarians who are in compliance with subdivision 6 and who are employed by the University of Minnesota from performing their duties with the College of Veterinary Medicine, College of Agriculture, Agricultural Experiment Station, Agricultural Extension Service, Medical School, School of Public Health, or other unit within the university; or a person from lecturing or giving instructions or demonstrations at the university or in connection with a continuing education course or seminar to veterinarians or pathologists at the University of Minnesota Veterinary Diagnostic Laboratory;

(f) any person from selling or applying any pesticide, insecticide or herbicide;

(g) any person from engaging in bona fide scientific research or investigations which reasonably requires experimentation involving animals;

(h) any employee of a licensed veterinarian from performing duties other than diagnosis, prescription or surgical correction under the direction and supervision of the veterinarian, who shall be responsible for the performance of the employee;

(i) a graduate of a foreign college of veterinary medicine from working under the direct personal instruction, control, or supervision of a veterinarian faculty member of the College of Veterinary Medicine, University of Minnesota in order to complete the requirements necessary to obtain an ECFVG or PAVE certificate;

(j) a licensed chiropractor registered under section 148.01, subdivision 1a, from practicing animal chiropractic~~.~~; or

(k) a person certified by the Emergency Medical Services Regulatory Board under chapter 144E from providing emergency medical care to a police dog wounded in the line of duty.

ARTICLE 5

PRESCRIPTION DRUGS

Section 1. **[62J.841] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 62J.841 to 62J.845, the following definitions apply.

Subd. 2. **Consumer Price Index.** "Consumer Price Index" means the Consumer Price Index, Annual Average, for All Urban Consumers, CPI-U: U.S. City Average, All Items, reported by the United States Department of Labor, Bureau of Labor Statistics, or its successor or, if the index is discontinued, an equivalent index reported by a federal authority or, if no such index is reported, "Consumer Price Index" means a comparable index chosen by the Bureau of Labor Statistics.

Subd. 3. **Generic or off-patent drug.** "Generic or off-patent drug" means any prescription drug for which any exclusive marketing rights granted under the Federal Food, Drug, and Cosmetic Act, section 351 of the federal Public Health Service Act, and federal patent law have expired, including any drug-device combination product for the delivery of a generic drug.

Subd. 4. **Manufacturer.** "Manufacturer" has the meaning provided in section 151.01, subdivision 14a.

Subd. 5. **Prescription drug.** "Prescription drug" means a drug for human use subject to United States Code, title 21, section 353(b)(1).

Subd. 6. **Wholesale acquisition cost.** "Wholesale acquisition cost" has the meaning provided in United States Code, title 42, section 1395w-3a.

Subd. 7. **Wholesale distributor.** "Wholesale distributor" has the meaning provided in section 151.441, subdivision 14.

Sec. 2. **[62J.842] EXCESSIVE PRICE INCREASES PROHIBITED.**

Subdivision 1. **Prohibition.** No manufacturer shall impose, or cause to be imposed, an excessive price increase, whether directly or through a wholesale distributor, pharmacy, or similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or delivered to any consumer in the state.

Subd. 2. **Excessive price increase.** A price increase is excessive for purposes of this section when:

(1) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds:

(i) 15 percent of the wholesale acquisition cost over the immediately preceding calendar year; or

(ii) 40 percent of the wholesale acquisition cost over the immediately preceding three calendar years; and

(2) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds $30 for:

(i) a 30-day supply of the drug; or

(ii) a course of treatment lasting less than 30 days.

Subd. 3. **Exemption.** It is not a violation of this section for a wholesale distributor or pharmacy to increase the price of a generic or off-patent drug if the price increase is directly attributable to additional costs for the drug imposed on the wholesale distributor or pharmacy by the manufacturer of the drug.

Sec. 3. **[62J.843] REGISTERED AGENT AND OFFICE WITHIN THE STATE.**

Any manufacturer that sells, distributes, delivers, or offers for sale any generic or off-patent drug in the state is required to maintain a registered agent and office within the state.

Sec. 4. **[62J.844] ENFORCEMENT.**

Subdivision 1. **Notification.** The commissioner of management and budget and any other state agency that provides or purchases a pharmacy benefit except the Department of Human Services, and any entity under contract with a state agency to provide a pharmacy benefit other than an entity under contract with the Department of Human Services, shall notify the manufacturer of a generic or off-patent drug, the attorney general, and the Board of Pharmacy of any price increase that is in violation of section 62J.842.

Subd. 2. **Submission of drug cost statement and other information by manufacturer; investigation by attorney general.** (a) Within 45 days of receiving a notice under subdivision 1, the manufacturer of the generic or off-patent drug shall submit a drug cost statement to the attorney general. The statement must:

(1) itemize the cost components related to production of the drug;

(2) identify the circumstances and timing of any increase in materials or manufacturing costs that caused any increase during the preceding calendar year, or preceding three calendar years as applicable, in the price of the drug; and

(3) provide any other information that the manufacturer believes to be relevant to a determination of whether a violation of section 62J.842 has occurred.

(b) The attorney general may investigate whether a violation of section 62J.842 has occurred, is occurring, or is about to occur, in accordance with section 8.31, subdivision 2.

Subd. 3. **Petition to court.** (a) On petition of the attorney general, a court may issue an order:

(1) compelling the manufacturer of a generic or off-patent drug to:

(i) provide the drug cost statement required under subdivision 2, paragraph (a); and

(ii) answer interrogatories, produce records or documents, or be examined under oath, as required by the attorney general under subdivision 2, paragraph (b);

(2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including issuing an order requiring that drug prices be restored to levels that comply with section 62J.842;

(3) requiring the manufacturer to provide an accounting to the attorney general of all revenues resulting from a violation of section 62J.842;

(4) requiring the manufacturer to repay to all consumers, including any third-party payers, any money acquired as a result of a price increase that violates section 62J.842;

(5) notwithstanding section 16A.151, requiring that all revenues generated from a violation of section 62J.842 be remitted to the state and deposited into a special fund, to be used for initiatives to reduce the cost to consumers of acquiring prescription drugs, if a manufacturer is unable to determine the individual transactions necessary to provide the repayments described in clause (4);

(6) imposing a civil penalty of up to $10,000 per day for each violation of section 62J.842;

(7) providing for the attorney general's recovery of its costs and disbursements incurred in bringing an action against a manufacturer found in violation of section 62J.842, including the costs of investigation and reasonable attorney's fees; and

(8) providing any other appropriate relief, including any other equitable relief as determined by the court.

(b) For purposes of paragraph (a), clause (6), every individual transaction in violation of section 62J.842 shall be considered a separate violation.

Subd. 4. **Private right of action.** Any action brought pursuant to section 8.31, subdivision 3a, by a person injured by a violation of this section is for the benefit of the public.

Sec. 5. **[62J.845] PROHIBITION ON WITHDRAWAL OF GENERIC OR OFF-PATENT DRUGS FOR SALE.**

Subdivision 1. **Prohibition.** A manufacturer of a generic or off-patent drug is prohibited from withdrawing that drug from sale or distribution within this state for the purpose of avoiding the prohibition on excessive price increases under section 62J.842.

Subd. 2. **Notice to board and attorney general.** Any manufacturer that intends to withdraw a generic or off-patent drug from sale or distribution within the state shall provide a written notice of withdrawal to the Board of Pharmacy and the attorney general, at least 180 days prior to the withdrawal.

Subd. 3. **Financial penalty.** The attorney general shall assess a penalty of $500,000 on any manufacturer of a generic or off-patent drug that it determines has failed to comply with the requirements of this section.

Sec. 6. **[62J.846] SEVERABILITY.**

If any provision of sections 62J.841 to 62J.845 or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of sections 62J.841 to 62J.845 that can be given effect without the invalid provision or application.

Sec. 7. Minnesota Statutes 2020, section 62Q.81, is amended by adding a subdivision to read:

Subd. 6. **Prescription drug benefits.** (a) A health plan company that offers individual health plans must ensure that no fewer than 25 percent of the individual health plans the company offers in each geographic area that the health plan company services at each level of coverage described in subdivision 1, paragraph (b), clause (3), applies a predeductible, flat-dollar amount co-payment structure to the entire drug benefit, including all tiers.

(b) A health plan company that offers small group health plans must ensure that no fewer than 25 percent of small group health plans the company offers in each geographic area that the health plan company services at each level of coverage described in subdivision 1,

paragraph (b), clause (3), applies a predeductible, flat-dollar amount co-payment structure to the entire drug benefit, including all tiers.

(c) The highest allowable co-payment for the highest cost drug tier for health plans offered pursuant to this subdivision must be no greater than 1/12 of the plan's out-of-pocket maximum for an individual.

(d) The flat-dollar amount co-payment tier structure for prescription drugs under this subdivision must be graduated and proportionate.

(e) All individual and small group health plans offered pursuant to this subdivision must be:

(1) clearly and appropriately named to aid the purchaser in the selection process;

(2) marketed in the same manner as other health plans offered by the health plan company; and

(3) offered for purchase to any individual or small group.

(f) This subdivision does not apply to catastrophic plans, grandfathered plans, large group health plans, health savings accounts (HSAs), qualified high deductible health benefit plans, limited health benefit plans, or short-term limited-duration health insurance policies.

(g) Health plan companies must meet the requirements in this subdivision separately for plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

EFFECTIVE DATE. This section is effective January 1, 2022, and applies to individual and small group health plans offered, issued, or renewed on or after that date.

Sec. 8. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

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

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Enrollee contract term" means the 12-month term during which benefits associated with health plan company products are in effect. For managed care plans and county-based purchasing plans under section 256B.69 and chapter 256L, it means a single calendar quarter.

(d) "Formulary" means a list of prescription drugs that have been developed by clinical and pharmacy experts and represents the health plan company's medically appropriate and cost-effective prescription drugs approved for use.

(e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and includes an entity that performs pharmacy benefits management for the health plan company.

(f) "Pharmacy benefits management" means the administration or management of prescription drug benefits provided by the health plan company for the benefit of its enrollees and may include but is not limited to procurement of prescription drugs, clinical formulary development and management services, claims processing, and rebate contracting and administration.

(g) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides prescription drug benefit coverage and uses a formulary must make its formulary and related benefit information available by electronic means and, upon request, in writing at least 30 days prior to annual renewal dates.

(b) Formularies must be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's Model Guidelines.

(c) For each item or category of items on the formulary, the specific enrollee benefit terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan company may, at any time during the enrollee's contract term:

(1) expand its formulary by adding drugs to the formulary;

(2) reduce co-payments or coinsurance; or

(3) move a drug to a benefit category that reduces an enrollee's cost.

(b) A health plan company may remove a brand name drug from its formulary or place a brand name drug in a benefit category that increases an enrollee's cost only upon the addition to the formulary of a generic or multisource brand name drug rated as therapeutically equivalent according to the Food and Drug Administration (FDA) Orange Book or a biologic drug rated as interchangeable according to the FDA Purple Book at a lower cost to the enrollee and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

(c) A health plan company may change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the enrollee's contract term upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided that these changes do not apply to enrollees who are currently taking the drugs affected by these changes for the duration of the enrollee's contract term.

(d) A health plan company may remove any drugs from its formulary that have been deemed unsafe by the FDA; that have been withdrawn by either the FDA or the product manufacturer; or when an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

Sec. 9. **[62W.0751] ALTERNATIVE BIOLOGICAL PRODUCTS.**

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

(b) "Biological product" has the meaning provided in section 151.01, subdivision 40.

(c) "Biosimilar" or "biosimilar product" has the meaning provided in section 151.01, subdivision 43.

(d) "Interchangeable biological product" has the meaning provided in section 151.01, subdivision 41.

(e) "Reference biological product" has the meaning provided in section 151.01, subdivision 44.

Subd. 2. **Pharmacy and provider choice related to dispensing reference biological products, interchangeable biological products, or biosimilar products.** (a) A pharmacy benefit manager or health carrier must not require or demonstrate a preference for a pharmacy or health care provider to prescribe or dispense a single biological product for which there is a United States Food and Drug Administration-approved biosimilar or interchangeable biological product relative to a reference biological product, except as provided in paragraph (b).

(b) If a pharmacy benefit manager or health carrier elects coverage of a product listed in paragraph (a), it must in addition also elect equivalent coverage for at least three reference, biosimilar, or interchangeable biological products, or the total number of products that have been approved by the United States Food and Drug Administration relative to the reference product if less than three, for which the wholesale acquisition cost is less than the wholesale acquisition cost of the product listed in paragraph (a).

(c) A pharmacy benefit manager or health carrier must not impose limits on access to a product required to be covered under paragraph (b) that are more restrictive than limits imposed on access to a product listed in paragraph (a), or that otherwise have the same effect as giving preferred status to a product listed in paragraph (a) over the product required to be covered under paragraph (b).

(d) This section does not apply to coverage provided through a public health care program under chapter 256B or 256L, or health plan coverage through the State Employee Group Insurance Plan (SEGIP) under chapter 43A.

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

Sec. 10. Minnesota Statutes 2020, section 62W.11, is amended to read:

62W.11 GAG CLAUSE PROHIBITION.

(a) No contract between a pharmacy benefit manager or health carrier and a pharmacy or pharmacist shall prohibit, restrict, or penalize a pharmacy or pharmacist from disclosing to an enrollee any health care information that the pharmacy or pharmacist deems appropriate regarding the nature of treatment; the risks or alternatives; the availability of alternative therapies, consultations, or tests; the decision of utilization reviewers or similar persons to authorize or deny services; the process that is used to authorize or deny health care services or benefits; or information on financial incentives and structures used by the health carrier or pharmacy benefit manager.

(b) A pharmacy or pharmacist must provide to an enrollee information regarding the enrollee's total cost for each prescription drug dispensed where part or all of the cost of the prescription is being paid or reimbursed by the employer-sponsored plan or by a health carrier or pharmacy benefit manager, in accordance with section 151.214, subdivision 1.

(c) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or pharmacy from discussing information regarding the total cost for pharmacy services for a prescription drug, including the patient's co-payment amount ~~and~~, the pharmacy's own usual and customary price ~~of~~ for the prescription drug, the pharmacy's acquisition cost for the prescription drug, and the amount the pharmacy is being reimbursed by the pharmacy benefit manager or health carrier for the prescription drug.

(d) A pharmacy benefit manager must not prohibit a pharmacist or pharmacy from discussing with a health carrier the amount the pharmacy is being paid or reimbursed for a prescription drug by the pharmacy benefit manager or the pharmacy's acquisition cost for a prescription drug.

~~(d)~~ (e) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or pharmacy from discussing the availability of any therapeutically equivalent alternative prescription drugs or alternative methods for purchasing the prescription drug, including but not limited to paying out-of-pocket the pharmacy's usual and customary price when that

amount is less expensive to the enrollee than the amount the enrollee is required to pay for the prescription drug under the enrollee's health plan.

Sec. 11. Minnesota Statutes 2019 Supplement, section 62W.12, is amended to read:

62W.12 POINT OF SALE.

(a) No pharmacy benefit manager or health carrier shall require an enrollee to make a payment at the point of sale for a covered prescription drug in an amount greater than the lesser of:

(1) the applicable co-payment for the prescription drug;

(2) the allowable claim amount for the prescription drug; ~~or~~

(3) the amount an enrollee would pay for the prescription drug if the enrollee purchased the prescription drug without using a health plan or any other source of prescription drug benefits or discounts; or

(4) the net price of the prescription drug.

(b) For purposes of this section, "net price" means the pharmacy benefit manager's or health carrier's cost for a prescription drug, after applying any rebates or discounts received by or accrued directly or indirectly to the pharmacy benefit manager or health carrier from a drug manufacturer.

EFFECTIVE DATE. This section is effective for health plans offered, issued, or renewed on or after January 1, 2022.

Sec. 12. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to read:

Subd. 43. **Biosimilar product.** "Biosimilar" or "interchangeable biological product" means a biological product that the United States Food and Drug Administration has licensed, and determined to be "biosimilar" under United States Code, title 42, section 262(i)(2).

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

Sec. 13. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to read:

Subd. 44. **Reference biological product.** "Reference biological product" means the single biological product for which the United States Food and Drug Administration has approved an initial biological product license application, against which other biological

products are evaluated for licensure as biosimilar products or interchangeable biological products.

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

Sec. 14. Minnesota Statutes 2020, section 151.071, subdivision 1, is amended to read:

Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee, registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do one or more of the following:

(1) deny the issuance of a license or registration;

(2) refuse to renew a license or registration;

(3) revoke the license or registration;

(4) suspend the license or registration;

(5) impose limitations, conditions, or both on the license or registration, including but not limited to: the limitation of practice to designated settings; the limitation of the scope of practice within designated settings; the imposition of retraining or rehabilitation requirements; the requirement of practice under supervision; the requirement of participation in a diversion program such as that established pursuant to section 214.31 or the conditioning of continued practice on demonstration of knowledge or skills by appropriate examination or other review of skill and competence;

(6) impose a civil penalty not exceeding $10,000 for each separate violation, except that a civil penalty not exceeding $25,000 may be imposed for each separate violation of section 62J.842, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant of any economic advantage gained by reason of the violation, to discourage similar violations by the licensee or registrant or any other licensee or registrant, or to reimburse the board for the cost of the investigation and proceeding, including but not limited to, fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members; and

(7) reprimand the licensee or registrant.

Sec. 15. Minnesota Statutes 2020, section 151.071, subdivision 2, is amended to read:

Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is grounds for disciplinary action:

(1) failure to demonstrate the qualifications or satisfy the requirements for a license or registration contained in this chapter or the rules of the board. The burden of proof is on the applicant to demonstrate such qualifications or satisfaction of such requirements;

(2) obtaining a license by fraud or by misleading the board in any way during the application process or obtaining a license by cheating, or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to: (i) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (ii) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf;

(3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration, conviction of a felony reasonably related to the practice of pharmacy. Conviction as used in this subdivision includes a conviction of an offense that if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon. The board may delay the issuance of a new license or registration if the applicant has been charged with a felony until the matter has been adjudicated;

(4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner or applicant is convicted of a felony reasonably related to the operation of the facility. The board may delay the issuance of a new license or registration if the owner or applicant has been charged with a felony until the matter has been adjudicated;

(5) for a controlled substance researcher, conviction of a felony reasonably related to controlled substances or to the practice of the researcher's profession. The board may delay the issuance of a registration if the applicant has been charged with a felony until the matter has been adjudicated;

(6) disciplinary action taken by another state or by one of this state's health licensing agencies:

(i) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration in another state or jurisdiction, failure to report to the board that charges or allegations regarding the person's license or registration have been brought in another state or jurisdiction, or having been refused a license or registration by any other state or jurisdiction. The board may delay the issuance of a new license or registration if an investigation or disciplinary action is pending in another state or jurisdiction until the investigation or action has been dismissed or otherwise resolved; and

(ii) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration issued by another of this state's health licensing agencies, failure to report to the board that charges regarding the person's license or registration have been brought by another of this state's health licensing agencies, or having been refused a license or registration by another of this state's health licensing agencies. The board may delay the issuance of a new license or registration if a disciplinary action is pending before another of this state's health licensing agencies until the action has been dismissed or otherwise resolved;

(7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of any order of the board, of any of the provisions of this chapter or any rules of the board or violation of any federal, state, or local law or rule reasonably pertaining to the practice of pharmacy;

(8) for a facility, other than a pharmacy, licensed by the board, violations of any order of the board, of any of the provisions of this chapter or the rules of the board or violation of any federal, state, or local law relating to the operation of the facility;

(9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient; or pharmacy practice that is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established;

(10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy technician or pharmacist intern if that person is performing duties allowed by this chapter or the rules of the board;

(11) for an individual licensed or registered by the board, adjudication as mentally ill or developmentally disabled, or as a chemically dependent person, a person dangerous to the public, a sexually dangerous person, or a person who has a sexual psychopathic personality, by a court of competent jurisdiction, within or without this state. Such adjudication shall automatically suspend a license for the duration thereof unless the board orders otherwise;

(12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist intern or performing duties specifically reserved for pharmacists under this chapter or the rules of the board;

(13) for a pharmacy, operation of the pharmacy without a pharmacist present and on duty except as allowed by a variance approved by the board;

(14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills. In the case of registered pharmacy technicians, pharmacist interns, or controlled substance researchers, the inability to carry out duties allowed under this chapter or the rules of the board with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills;

(15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas dispenser, or controlled substance researcher, revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law;

(16) for a pharmacist or pharmacy, improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

(17) fee splitting, including without limitation:

(i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

(ii) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the licensee or registrant has a financial or economic interest as defined

in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the licensee's or registrant's financial or economic interest in accordance with section 144.6521; and

(iii) any arrangement through which a pharmacy, in which the prescribing practitioner does not have a significant ownership interest, fills a prescription drug order and the prescribing practitioner is involved in any manner, directly or indirectly, in setting the price for the filled prescription that is charged to the patient, the patient's insurer or pharmacy benefit manager, or other person paying for the prescription or, in the case of veterinary patients, the price for the filled prescription that is charged to the client or other person paying for the prescription, except that a veterinarian and a pharmacy may enter into such an arrangement provided that the client or other person paying for the prescription is notified, in writing and with each prescription dispensed, about the arrangement, unless such arrangement involves pharmacy services provided for livestock, poultry, and agricultural production systems, in which case client notification would not be required;

(18) engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws or rules;

(19) engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

(20) failure to make reports as required by section 151.072 or to cooperate with an investigation of the board as required by section 151.074;

(21) knowingly providing false or misleading information that is directly related to the care of a patient unless done for an accepted therapeutic purpose such as the dispensing and administration of a placebo;

(22) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board must investigate any complaint of a violation of section 609.215, subdivision 1 or 2;

(23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For a pharmacist intern, pharmacy technician, or controlled substance researcher, performing duties permitted to such individuals by this chapter or the rules of the board under a lapsed or nonrenewed registration. For a facility required to be licensed under this chapter, operation of the facility under a lapsed or nonrenewed license or registration; ~~and~~

(24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge from the health professionals services program for reasons other than the satisfactory completion of the program~~.~~; and

(25) for a manufacturer, a violation of section 62J.842 or section 62J.845.

Sec. 16. **[151.335] DELIVERY THROUGH COMMON CARRIER; COMPLIANCE WITH TEMPERATURE REQUIREMENTS.**

In addition to complying with the requirements of Minnesota Rules, part 6800.3000, a mail order or specialty pharmacy that employs the United States Postal Service or other common carrier to deliver a filled prescription directly to a patient must ensure that the drug is delivered in compliance with temperature requirements established by the manufacturer of the drug. The methods used to ensure compliance must include but are not limited to enclosing in each medication's packaging a method recognized by the United States Pharmacopeia by which the patient can easily detect improper storage or temperature variations.

Sec. 17. Minnesota Statutes 2020, section 151.555, subdivision 1, is amended to read:

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

(b) "Central repository" means a wholesale distributor that meets the requirements under subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this section.

(c) "Distribute" means to deliver, other than by administering or dispensing.

(d) "Donor" means:

(1) a health care facility as defined in this subdivision;

(2) a skilled nursing facility licensed under chapter 144A;

(3) an assisted living facility registered under chapter 144D where there is centralized storage of drugs and 24-hour on-site licensed nursing coverage provided seven days a week;

(4) a pharmacy licensed under section 151.19, and located either in the state or outside the state;

(5) a drug wholesaler licensed under section 151.47;

(6) a drug manufacturer licensed under section 151.252; or

(7) an individual at least 18 years of age, provided that the drug or medical supply that is donated was obtained legally and meets the requirements of this section for donation.

(e) "Drug" means any prescription drug that has been approved for medical use in the United States, is listed in the United States Pharmacopoeia or National Formulary, and meets the criteria established under this section for donation; or any over-the-counter medication that meets the criteria established under this section for donation. This definition includes cancer drugs and antirejection drugs, but does not include controlled substances, as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed to a patient registered with the drug's manufacturer in accordance with federal Food and Drug Administration requirements.

(f) "Health care facility" means:

(1) a physician's office or health care clinic where licensed practitioners provide health care to patients;

(2) a hospital licensed under section 144.50;

(3) a pharmacy licensed under section 151.19 and located in Minnesota; or

(4) a nonprofit community clinic, including a federally qualified health center; a rural health clinic; public health clinic; or other community clinic that provides health care utilizing a sliding fee scale to patients who are low-income, uninsured, or underinsured.

(g) "Local repository" means a health care facility that elects to accept donated drugs and medical supplies and meets the requirements of subdivision 4.

(h) "Medical supplies" or "supplies" means any prescription and nonprescription medical supplies needed to administer a prescription drug.

(i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or

unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules, part 6800.3750.

(j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that it does not include a veterinarian.

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

Sec. 18. Minnesota Statutes 2020, section 151.555, subdivision 7, is amended to read:

Subd. 7. **Standards and procedures for inspecting and storing donated prescription drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or under contract with the central repository or a local repository shall inspect all donated prescription drugs and supplies before the drug or supply is dispensed to determine, to the extent reasonably possible in the professional judgment of the pharmacist or practitioner, that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing, has not been subject to a recall, and meets the requirements for donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an inspection record stating that the requirements for donation have been met. If a local repository receives drugs and supplies from the central repository, the local repository does not need to reinspect the drugs and supplies.

(b) The central repository and local repositories shall store donated drugs and supplies in a secure storage area under environmental conditions appropriate for the drug or supply being stored. Donated drugs and supplies may not be stored with nondonated inventory. ~~If donated drugs or supplies are not inspected immediately upon receipt, a repository must quarantine the donated drugs or supplies separately from all dispensing stock until the donated drugs or supplies have been inspected and (1) approved for dispensing under the program; (2) disposed of pursuant to paragraph (c); or (3) returned to the donor pursuant to paragraph (d).~~

(c) The central repository and local repositories shall dispose of all prescription drugs and medical supplies that are not suitable for donation in compliance with applicable federal and state statutes, regulations, and rules concerning hazardous waste.

(d) In the event that controlled substances or prescription drugs that can only be dispensed to a patient registered with the drug's manufacturer are shipped or delivered to a central or local repository for donation, the shipment delivery must be documented by the repository and returned immediately to the donor or the donor's representative that provided the drugs.

(e) Each repository must develop drug and medical supply recall policies and procedures. If a repository receives a recall notification, the repository shall destroy all of the drug or medical supply in its inventory that is the subject of the recall and complete a record of destruction form in accordance with paragraph (f). If a drug or medical supply that is the subject of a Class I or Class II recall has been dispensed, the repository shall immediately notify the recipient of the recalled drug or medical supply. A drug that potentially is subject to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

(f) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation shall be maintained by the repository for at least ~~five~~ two years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the drug destroyed; and

(3) the name of the person or firm that destroyed the drug.

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

Sec. 19. Minnesota Statutes 2020, section 151.555, subdivision 11, is amended to read:

Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed for the administration of this program shall be utilized by the participants of the program and shall be available on the board's website:

(1) intake application form described under subdivision 5;

(2) local repository participation form described under subdivision 4;

(3) local repository withdrawal form described under subdivision 4;

(4) drug repository donor form described under subdivision 6;

(5) record of destruction form described under subdivision 7; and

(6) drug repository recipient form described under subdivision 8.

(b) All records, including drug inventory, inspection, and disposal of donated prescription drugs and medical supplies, must be maintained by a repository for a minimum of ~~five~~ two years. Records required as part of this program must be maintained pursuant to all applicable practice acts.

(c) Data collected by the drug repository program from all local repositories shall be submitted quarterly or upon request to the central repository. Data collected may consist of the information, records, and forms required to be collected under this section.

(d) The central repository shall submit reports to the board as required by the contract or upon request of the board.

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

Sec. 20. Minnesota Statutes 2020, section 151.555, is amended by adding a subdivision to read:

Subd. 14. **Cooperation.** The central repository, as approved by the Board of Pharmacy, may enter into an agreement with another state that has an established drug repository or drug donation program if the other state's program includes regulations to ensure the purity, integrity, and safety of the drugs and supplies donated, to permit the central repository to offer to another state program inventory that is not needed by a Minnesota resident and to accept inventory from another state program to be distributed to local repositories and dispensed to Minnesota residents in accordance with this program.

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

Sec. 21. Minnesota Statutes 2018, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

(c) Managed care plans and county-based purchasing plans must comply with section 62Q.83.

Sec. 22. **STUDY OF PHARMACY AND PROVIDER CHOICE OF BIOLOGICAL PRODUCTS.**

The commissioner of health, within the limits of existing resources, shall analyze the effect of Minnesota Statutes, section 62W.0751, on the net price for different payors of biological products, interchangeable biological products, and biosimilar products. The commissioner of health shall report findings to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, and insurance, by December 15, 2023.

ARTICLE 6
HEALTH INSURANCE

Section 1. Minnesota Statutes 2020, section 62A.04, subdivision 2, is amended to read:

Subd. 2. **Required provisions.** Except as provided in subdivision 4 each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subdivision in the words in which the same appear in this section. The insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subdivision or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) A provision as follows:

TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two year period, nor to limit the application of clauses (1), (2), (3), (4) and (5), in the event of misstatement with respect to age or occupation or other insurance. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(3)(a) Except as required for qualified health plans sold through MNsure to individuals receiving advance payments of the premium tax credit, a provision as follows:

GRACE PERIOD: A grace period of ..... (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

A policy which contains a cancellation provision may add, at the end of the above provision,

subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision,

Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.

(b) For ~~qualified~~ individual and small group health plans ~~sold through MNsure to individuals receiving advance payments of the premium tax credit~~, a grace period provision must be included that complies with ~~the Affordable Care Act and is no less restrictive than the grace period required by the Affordable Care Act~~ section 62A.65, subdivision 2a.

(4) A provision as follows:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. For health plans described in section 62A.011, subdivision 3, clause (10), an insurer must accept payment of a renewal premium and reinstate the policy, if the insured applies for reinstatement no later than 60 days after the due date for the premium payment, unless:

(1) the insured has in the interim left the state or the insurer's service area; or

(2) the insured has applied for reinstatement on two or more prior occasions.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the

defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement. The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.

(5) A provision as follows:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

(6) A provision as follows:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(7) A provision as follows:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(8) A provision as follows:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(9) A provision as follows:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $..... (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

(10) A provision as follows:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision as follows:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(12) A provision as follows:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy. The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2020, section 62A.10, is amended by adding a subdivision to read:

Subd. 5. **Prohibition on waiting periods that exceed 90 days.** (a) For purposes of this subdivision, "waiting period" means the period that must pass before coverage becomes effective for an individual who is otherwise eligible to enroll under the terms of a group health plan.

(b) A health carrier offering a group health plan must not apply a waiting period that exceeds 90 days, with exceptions for the circumstances described in paragraphs (c) to (e). A health carrier does not violate this subdivision solely because an individual is permitted to take additional time to elect coverage beyond the end of the 90-day waiting period.

(c) If a group health plan conditions eligibility on an employee working full time or regularly having a specified number of service hours per period, and the plan is unable to determine whether a newly hired employee is full time or reasonably expected to regularly work the specific number of hours per period, the plan may take a reasonable period of time, not to exceed 12 months beginning on any date between the employee's start date and the first day of the first calendar month after the employee's start date, to determine whether the employee meets the plan's eligibility condition.

(d) If a group health plan conditions eligibility on an employee having completed a cumulative number of service hours, the cumulative hours-of-service requirement must not exceed 1,200 hours.

(e) An orientation period may be added to the 90-day waiting period if the orientation period is one month or less. The one-month period is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage.

(f) A group health plan may treat an employee whose employment has terminated and is later rehired as newly eligible upon rehire and require the rehired employee to meet the plan's eligibility criteria and waiting period again, if doing so is reasonable under the circumstances. Treating an employee as rehired is reasonable if the employee has a break in service of at least 13 weeks, or at least 26 weeks if the employer is an educational institution.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2020, section 62A.65, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** No health carrier, as defined in section 62A.011, shall offer, sell, issue, or renew any individual health plan, as defined in section 62A.011, to a Minnesota resident except in compliance with this section. ~~This section does not apply to the Comprehensive Health Association established in section 62E.10.~~ A health carrier must only offer, sell, issue, or renew individual health plans on a guaranteed issue basis and at a premium rate that does not vary based on the health status of the individual.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 4. Minnesota Statutes 2020, section 62A.65, is amended by adding a subdivision to read:

Subd. 2a. **Grace period for nonpayment of premium.** (a) Notwithstanding any other law to the contrary, an individual health plan may be canceled for nonpayment of premiums, but must include a grace period as described in this subdivision.

(b) The grace period must be three consecutive months. During the grace period, the health carrier must:

(1) pay all claims for services that would have been covered if the premium had been paid, which are provided to the enrollee during the first month of the grace period, and may pend claims for services provided to an enrollee in the second and third months of the grace period; and

(2) notify health care providers of the possibility of denied claims when an enrollee is in the second and third month of the grace period.

(c) In order to stop a cancellation, an enrollee must pay all outstanding premiums before the end of the grace period.

(d) If a health plan is canceled under this subdivision, the final day of the enrollment is the last day of the first month of the three-month grace period.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 5. Minnesota Statutes 2020, section 62D.095, subdivision 2, is amended to read:

Subd. 2. **Co-payments.** A health maintenance contract may impose a co-payment and coinsurance consistent with ~~the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a~~ state and federal law.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 6. Minnesota Statutes 2020, section 62D.095, subdivision 3, is amended to read:

Subd. 3. **Deductibles.** A health maintenance contract may impose a deductible consistent with ~~the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a~~ state and federal law.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 7. Minnesota Statutes 2020, section 62D.095, subdivision 4, is amended to read:

Subd. 4. **Annual out-of-pocket maximums.** A health maintenance contract may impose an annual out-of-pocket maximum consistent with the provisions of ~~the Affordable Care Act as defined under section 62A.011, subdivision 1a~~ section 62Q.677, subdivision 6a.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 8. Minnesota Statutes 2020, section 62D.095, subdivision 5, is amended to read:

Subd. 5. **Exceptions.** No co-payments or deductibles may be imposed on preventive ~~health care~~ items and services ~~consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a~~, as defined in section 62Q.46, subdivision 1.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 9. Minnesota Statutes 2020, section 62Q.01, subdivision 2a, is amended to read:

Subd. 2a. **Dependent child to the limiting age.** "Dependent child to the limiting age" or "dependent children to the limiting age" means those individuals who are eligible and covered as a dependent child under the terms of a health plan who have not yet attained 26 years of age. A health plan company must not deny or restrict eligibility for a dependent child to the limiting age based on financial dependency, residency, marital status, or student status. For coverage under plans offered by the Minnesota Comprehensive Health Association, dependent to the limiting age means dependent as defined in section 62A.302, subdivision 3. Notwithstanding the provisions in this subdivision, a health plan may include:

(1) eligibility requirements regarding the absence of other health plan coverage ~~as permitted by the Affordable Care Act~~ for grandfathered plan coverage; or

(2) an age greater than 26 in its policy, contract, or certificate of coverage.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 10. **[62Q.097] REQUIREMENTS FOR TIMELY PROVIDER CREDENTIALING.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Clean application for provider credentialing" or "clean application" means an application for provider credentialing submitted by a health care provider to a health plan company that is complete, is in the format required by the health plan company, and includes all information and substantiation required by the health plan company and does not require evaluation of any identified potential quality or safety concern.

(c) "Provider credentialing" means the process undertaken by a health plan company to evaluate and approve a health care provider's education, training, residency, licenses, certifications, and history of significant quality or safety concerns in order to approve the health care provider to provide health care services to patients at a clinic or facility.

Subd. 2. **Time limit for credentialing determination.** A health plan company that receives an application for provider credentialing must:

(1) if the application is determined to be a clean application for provider credentialing and if the health care provider submitting the application or the clinic or facility at which the health care provider provides services requests the information, affirm that the health care provider's application is a clean application and notify the health care provider or clinic or facility of the date by which the health plan company will make a determination on the health care provider's application;

(2) if the application is determined not to be a clean application, inform the health care provider of the application's deficiencies or missing information or substantiation within three business days after the health plan company determines the application is not a clean application; and

(3) make a determination on the health care provider's clean application within 45 days after receiving the clean application unless the health plan company identifies a substantive quality or safety concern in the course of provider credentialing that requires further investigation. Upon notice to the health care provider, clinic, or facility, the health plan company is allowed 30 additional days to investigate any quality or safety concerns.

EFFECTIVE DATE. This section applies to applications for provider credentialing submitted to a health plan company on or after January 1, 2022.

Sec. 11. Minnesota Statutes 2020, section 62Q.46, is amended to read:

62Q.46 PREVENTIVE ITEMS AND SERVICES.

Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and services" ~~has the meaning specified in the Affordable Care Act~~ means the items and services categorized as preventive under subdivision 1a.

(b) A health plan company must provide coverage for preventive items and services at a participating provider without imposing cost-sharing requirements, including a deductible, coinsurance, or co-payment. Nothing in this section prohibits a health plan company that has a network of providers from excluding coverage or imposing cost-sharing requirements for preventive items or services that are delivered by an out-of-network provider.

(c) A health plan company is not required to provide coverage for any items or services specified in any recommendation or guideline described in paragraph (a) if the recommendation or guideline is no longer included as a preventive item or service as defined in paragraph (a). Annually, a health plan company must determine whether any additional items or services must be covered without cost-sharing requirements or whether any items or services are no longer required to be covered.

(d) Nothing in this section prevents a health plan company from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for a preventive item or service to the extent not specified in the recommendation or guideline.

(e) This section does not apply to grandfathered plans.

(f) This section does not apply to plans offered by the Minnesota Comprehensive Health Association.

Subd. 1a. **Preventive items and services.** The commissioner of commerce must provide health plan companies with information regarding which items and services must be categorized as preventive.

Subd. 2. **Coverage for office visits in conjunction with preventive items and services.** (a) A health plan company may impose cost-sharing requirements with respect to an office visit if a preventive item or service is billed separately or is tracked separately as individual encounter data from the office visit.

(b) A health plan company must not impose cost-sharing requirements with respect to an office visit if a preventive item or service is not billed separately or is not tracked separately as individual encounter data from the office visit and the primary purpose of the office visit is the delivery of the preventive item or service.

(c) A health plan company may impose cost-sharing requirements with respect to an office visit if a preventive item or service is not billed separately or is not tracked separately as individual encounter data from the office visit and the primary purpose of the office visit is not the delivery of the preventive item or service.

Subd. 3. **Additional services not prohibited.** Nothing in this section prohibits a health plan company from providing coverage for preventive items and services in addition to those specified in ~~the Affordable Care Act~~ subdivision 1a, or from denying coverage for preventive items and services that are not recommended as preventive items and services under ~~the Affordable Care Act~~ subdivision 1a. A health plan company may impose cost-sharing requirements for a treatment not described in ~~the Affordable Care Act~~ subdivision 1a even if the treatment results from a preventive item or service described in ~~the Affordable Care Act~~ subdivision 1a.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 12. **[62Q.472] SCREENING AND TESTING FOR OPIOIDS.**

(a) A health plan company shall not place a lifetime or annual limit on screenings and urinalysis testing for opioids for an enrollee in an inpatient or outpatient substance use disorder treatment program when ordered by a health care provider and performed by an accredited clinical laboratory. A health plan company is not prohibited from conducting a medical necessity review when screenings or urinalysis testing for an enrollee exceeds 24 tests in any 12-month period.

(b) This section does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to public health care program enrollees under chapter 256B or 256L.

EFFECTIVE DATE. This section is effective January 1, 2022, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 13. **[62Q.521] COVERAGE OF CONTRACEPTIVES AND CONTRACEPTIVE SERVICES.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Closely held for-profit entity" means an entity that:

(1) is not a nonprofit entity;

(2) has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer individuals, or has an ownership structure that is substantially similar; and

(3) has no publicly traded ownership interest, having any class of common equity securities required to be registered under United States Code, title 15, section 781.

For purposes of this paragraph:

(i) ownership interests owned by a corporation, partnership, estate, or trust are considered owned proportionately by that entity's shareholders, partners, or beneficiaries;

(ii) ownership interests owned by a nonprofit entity are considered owned by a single owner;

(iii) ownership interests owned by an individual are considered owned, directly or indirectly, by or for the individual's family. For purposes of this item, "family" means brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

(iv) if an individual or entity holds an option to purchase an ownership interest, the individual or entity is considered to be the owner of those ownership interests.

(c) "Contraceptive" means a drug, device, or other product approved by the Food and Drug Administration to prevent unintended pregnancy.

(d) "Contraceptive service" means consultation, examination, procedure, and medical service related to the prevention of unintended pregnancy. This includes but is not limited to voluntary sterilization procedures, patient education, counseling on contraceptives, and follow-up services related to contraceptives or contraceptive services, management of side effects, counseling for continued adherence, and device insertion or removal.

(e) "Eligible organization" means an organization that opposes providing coverage for some or all contraceptives or contraceptive services on account of religious objections and that is:

(1) organized as a nonprofit entity and holds itself as a religious employer; or

(2) organized and operates as a closely held for-profit entity, and the organization's highest governing body has adopted, under the organization's applicable rules of governance and consistent with state law, a resolution or similar action establishing that it objects to covering some or all contraceptives or contraceptive services on account of the owners' sincerely held religious beliefs.

(f) "Medical necessity" includes but is not limited to considerations such as severity of side effects, difference in permanence and reversibility of a contraceptive or contraceptive service, and ability to adhere to the appropriate use of the contraceptive method or service, as determined by the attending provider.

(g) "Religious employer" means an organization that is organized and operates as a nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(h) "Therapeutic equivalent version" means a drug, device, or product that can be expected to have the same clinical effect and safety profile when administered to a patient under the conditions specified in the labeling, and that:

(1) is approved as safe and effective;

(2) is a pharmaceutical equivalent, (i) containing identical amounts of the same active drug ingredient in the same dosage form and route of administration, and (ii) meeting compendial or other applicable standards of strength, quality, purity, and identity;

(3) is bioequivalent in that:

(i) the drug, device, or product does not present a known or potential bioequivalence problem and meet an acceptable in vitro standard; or

(ii) if the drug, device, or product does present a known or potential bioequivalence problem, it is shown to meet an appropriate bioequivalence standard;

(4) is adequately labeled; and

(5) is manufactured in compliance with current manufacturing practice regulations.

Subd. 2. **Required coverage; cost sharing prohibited.** (a) A health plan must provide coverage for all prescription contraceptives and contraceptive services.

(b) A health plan company must not impose cost-sharing requirements, including co-pays, deductibles, or co-insurance, for contraceptives or contraceptive services.

(c) Notwithstanding paragraph (b), a health plan that is a high-deductible health plan in conjunction with a health savings account must include cost-sharing for contraceptives and contraceptive services at the minimum level necessary to preserve the enrollee's ability to make tax exempt contributions and withdrawals from the health savings account, as provided by section 223 of the Internal Revenue Code of 1986, as amended.

(d) A health plan company must not impose any referral requirements, restrictions, or delays for contraceptives or contraceptive services.

(e) If more than one therapeutic equivalent version of a contraceptive is approved by the FDA, a health plan must cover at least one therapeutic equivalent version, but is not required to cover all therapeutic equivalent versions.

(f) For each health plan, a health plan company must list the contraceptives and contraceptive services that are covered without cost-sharing in a manner that is easily accessible to enrollees, health care providers, and representatives of health care providers. The list for each health plan must be promptly updated to reflect changes to the coverage.

(g) If an enrollee's attending provider recommends a particular contraceptive or contraceptive service based on a determination of medical necessity for that enrollee, the health plan must cover that contraceptive or contraceptive service without cost-sharing. The health plan company issuing the health plan must defer to the attending provider's determination that the particular contraceptive or contraceptive service is medically necessary for the enrollee.

Subd. 3. **Religious employers; exempt** (a) A religious employer is not required to cover contraceptives or contraceptive services if the employer has religious objections to the coverage. A religious employer that chooses to not provide coverage for some or all contraceptives and contraceptive services must notify employees as part of the hiring process and all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(b) If the religious employer provides coverage for some contraceptives or contraceptive services, the notice must provide a list of the contraceptives or contraceptive services the employer refuses to cover.

Subd. 4. **Accommodation for eligible organizations.** (a) A health plan established or maintained by an eligible organization complies with the requirements of subdivision 2 to provide coverage of contraceptives and contraceptive services if the eligible organization provides notice to any health plan company the eligible organization contracts with that it is an eligible organization and that the eligible organization has a religious objection to coverage for all or a subset of contraceptives or contraceptive services.

(b) The notice from an eligible organization to a health plan company under paragraph (a) must include the name of the eligible organization, a statement that it objects to coverage for some or all of contraceptives or contraceptive services, including a list of the contraceptive services the eligible organization objects to, if applicable, and the health plan name. The

notice must be executed by a person authorized to provide notice on behalf of the eligible organization.

(c) An eligible organization must provide a copy of the notice under paragraph (b) to prospective employees as part of the hiring process and to all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(d) A health plan company that receives a copy of the notice under paragraph (a) with respect to a health plan established or maintained by an eligible organization must:

(1) expressly exclude coverage for some or all contraceptives or contraceptive services from the health plan and provide separate payments for any contraceptive or contraceptive service required to be covered under subdivision 2 for enrollees as long as the enrollee remains enrolled in the health plan; or

(2) arrange for an issuer or other entity to provide payments for contraceptive services for plan participants and beneficiaries without imposing any cost-sharing requirements, or imposing a premium fee or other charge, or any portion thereof directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries.

(e) The health plan company must not impose any cost-sharing requirements, including co-pays, deductibles, or co-insurance, or directly or indirectly impose any premium, fee, or other charge for contraceptive services or contraceptives on the eligible organization, health plan, or enrollee.

(f) On January 1, 2022, and every year thereafter a health plan company must notify the commissioner, in a manner to be determined by the commissioner, regarding the number of eligible organizations granted an accommodation under this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2022, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 14. **[62Q.522] COVERAGE FOR PRESCRIPTION CONTRACEPTIVES; SUPPLY REQUIREMENTS.**

Subdivision 1. **Scope of coverage.** Except as otherwise provided in section 62Q.521, subdivision 3, all health plans that provide prescription coverage must comply with the requirements of this section.

Subd. 2. **Definition.** For purposes of this section, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug that prevents pregnancy when administered after sexual contact.

Subd. 3. **Required coverage.** (a) Health plan coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive, regardless of whether the enrollee was covered by the health plan at the time of the first dispensing.

(b) The prescribing health care provider must determine the appropriate number of months to prescribe the prescription contraceptives for, up to 12 months.

EFFECTIVE DATE. This section is effective January 1, 2022, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 15. Minnesota Statutes 2020, section 62Q.677, is amended by adding a subdivision to read:

Subd. 6a. **Out-of-pocket annual maximum.** By October of each year, the commissioner of commerce must determine the maximum annual out-of-pocket limits applicable to individual health plans and small group health plans.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 16. Minnesota Statutes 2020, section 62Q.81, is amended to read:

62Q.81 ESSENTIAL HEALTH BENEFIT PACKAGE REQUIREMENTS.

Subdivision 1. **Essential health benefits package.** (a) Health plan companies offering individual and small group health plans must include the essential health benefits package ~~required under section 1302(a) of the Affordable Care Act and as~~ described in this subdivision.

(b) The essential health benefits package means insurance coverage that:

(1) provides the essential health benefits ~~as outlined in the Affordable Care Act~~ described in subdivision 4;

(2) limits cost-sharing for ~~such~~ the coverage ~~in accordance with the Affordable Care Act~~, as described in subdivision 2; and

(3) ~~subject to subdivision 3,~~ provides bronze, silver, gold, or platinum level of coverage ~~in accordance with the Affordable Care Act~~, as described in subdivision 3.

Subd. 2. **Cost-sharing; coverage for enrollees under the age of 21.** (a) Cost-sharing includes (1) deductibles, coinsurance, co-payments, or similar charges, and (2) qualified medical expenses, as defined in section 223(d)(2) of the Internal Revenue Code of 1986, as amended. Cost-sharing does not include premiums, balance billing from non-network providers, or spending for noncovered services.

(b) Cost-sharing per year for individual health plans is limited to the amount allowed under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, as amended, increased by an amount equal to the product of that amount and the premium adjustment percentage. The premium adjustment percentage is the percentage that the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds the average per capita premium for 2017. If the amount of the increase is not a multiple of $50, the increases must be rounded to the next lowest multiple of $50.

(c) Cost-sharing per year for small group health plans is limited to twice the amount allowed under paragraph (b).

(d) If a health plan company offers health plans in any level of coverage ~~specified under section 1302(d) of the Affordable Care Act, as~~ described in subdivision ~~1, paragraph (b), clause (3)~~ 3, the health plan company shall also offer coverage in that level to individuals who have not attained 21 years of age as of the beginning of a policy year.

Subd. 3. **Levels of coverage; alternative compliance for catastrophic plans.** (a) A health plan in the bronze level must provide a level of coverage designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(b) A health plan in the silver level must provide a level of coverage designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(c) A health plan in the gold level must provide a level of coverage designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(d) A health plan in the platinum level must provide a level of coverage designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(e) A health plan company that does not provide an individual or small group health plan in the bronze, silver, gold, or platinum level of coverage~~, as described in subdivision 1, paragraph (b), clause (3), shall be treated as meeting~~ meets the requirements of this section ~~1302(d) of the Affordable Care Act~~ with respect to any ~~policy~~ plan year if the health plan company provides a catastrophic plan that meets the following requirements ~~of section 1302(e) of the Affordable Care Act.~~:

(1) enrollment in the health plan is limited only to individuals that:

(i) have not attained age 30 before the beginning of the plan year;

(ii) are unable to access affordable coverage; or

(iii) are experiencing a hardship in reference to the individual's capability to access coverage; and

(2) the health plan provides:

(i) essential health benefits, except that the plan does not provide benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the limitation in effect under subdivision 2; and

(ii) coverage for at least three primary care visits.

Subd. 4. **Essential health benefits; definition.** (a) For purposes of this section, "essential health benefits" ~~has the meaning given under section 1302(b) of the Affordable Care Act and includes~~ means:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) laboratory services;

(5) maternity and newborn care;

(6) mental health and substance use disorder services, including behavioral health treatment;

(7) pediatric services, including oral and vision care;

(8) prescription drugs;

(9) preventive and wellness services and chronic disease management;

(10) rehabilitative and habilitative services and devices; and

(11) additional essential health benefits included in the ~~EHB-benchmark plan, as defined under the Affordable Care Act~~ health plan described in paragraph (c).

(b) If a service provider does not have a contractual relationship with the health plan to provide services, emergency services must be provided without imposing any prior authorization requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from providers who have a contractual relationship with the health plan. If services are provided out-of-network, the cost-sharing must be equivalent to services provided in-network.

(c) The scope of essential health benefits under paragraph (a) must be equal to the scope of benefits provided under a typical employer plan.

(d) Essential health benefits must:

(1) reflect an appropriate balance among the categories to ensure benefits are not unduly weighted toward any category;

(2) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in a manner that discriminates against individuals on the basis of age, disability, or expected length of life;

(3) account for the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups; and

(4) ensure that health benefits established as essential are not subject to denial against the individual's wishes on the basis of the individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency, or quality of life.

Subd. 5. **Exception.** This section does not apply to a dental plan ~~described in section 1311(d)(2)(B)(ii) of the Affordable Care Act~~ that is limited in scope and provides pediatric dental benefits.

EFFECTIVE DATE. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 17. Minnesota Statutes 2020, section 256B.0625, subdivision 10, is amended to read:

Subd. 10. **Laboratory and x-ray services.** (a) Medical assistance covers laboratory and x-ray services.

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

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

Sec. 18. Minnesota Statutes 2020, section 256B.0625, subdivision 13, is amended to read:

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

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

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

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

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

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

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the Formulary Committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A

pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

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

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

(h) Medical assistance coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive. The prescribing health care provider must determine the appropriate number of months to prescribe the prescription contraceptives for, up to 12 months.

For purposes of this paragraph, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug approved to prevent pregnancy when administered after sexual contact.

EFFECTIVE DATE. This section applies to medical assistance and MinnesotaCare coverage effective January 1, 2022.

Sec. 19. **COMMISSIONER OF COMMERCE; DETERMINATION OF PREVENTIVE ITEMS AND SERVICES.**

The commissioner of commerce must determine the items and services that are preventive under Minnesota Statutes, section 62Q.46, subdivision 1a. Items and services that are preventive must include:

(1) evidence-based items or services that have in effect a rating of A or B pursuant to the recommendations of the United States Preventive Services Task Force in effect January 1, 2021, and with respect to the individual involved;

(2) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For the purposes of this clause, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) with respect to women, additional preventive care and screenings not described in clause (1), as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

ARTICLE 7
TELEHEALTH

Section 1. **[62A.673] COVERAGE OF SERVICES PROVIDED THROUGH TELEHEALTH.**

Subdivision 1. **Citation.** This section may be cited as the "Minnesota Telehealth Act."

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

(b) "Distant site" means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.

(c) "Health care provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law. A health care provider includes a mental health professional as defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; a mental health practitioner as defined under section 245.462, subdivision 17, or 245.4871, subdivision 26; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

(d) "Health carrier" has the meaning given in section 62A.011, subdivision 2.

(e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

(f) "Originating site" means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth. For purposes of store-and-forward transfer, the originating site also means the location at which a health care provider transfers or transmits information to the distant site.

(g) "Store-and-forward transfer" means the asynchronous electronic transfer of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

(h) "Telehealth" means the delivery of health care services or consultations through the use of real-time, two-way interactive audio and visual or audio-only communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward transfers, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Telehealth includes audio-only communication between a health care provider and a patient if the communication is a scheduled appointment and the standard of care for the service can be met through the use of audio-only communication. Telehealth does not include communication between health care providers or between a health care provider and a patient that consists solely of an e-mail or facsimile transmission. Telehealth does not include communication between health care providers that consists solely of a telephone conversation.

(i) "Telemonitoring services" means the remote monitoring of clinical data related to the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect an enrollee's health-related data for the purpose of assisting a health care provider in assessing and monitoring the enrollee's medical condition or status.

Subd. 3. **Coverage of telehealth.** (a) A health plan sold, issued, or renewed by a health carrier in Minnesota must (1) cover benefits delivered through telehealth in the same manner as any other benefits covered under the health plan, and (2) comply with this section.

(b) Coverage for services delivered through telehealth must not be limited on the basis of geography, location, or distance for travel.

(c) A health carrier must not create a separate provider network or provide incentives to enrollees to use a separate provider network to deliver services through telehealth that does not include network providers who provide in-person care to patients for the same service.

(d) A health carrier may require a deductible, co-payment, or coinsurance payment for a health care service provided through telehealth, provided that the deductible, co-payment, or coinsurance payment is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable for the same service provided through in-person contact.

(e) Nothing in this section:

(1) requires a health carrier to provide coverage for services that are not medically necessary or are not covered under the enrollee's health plan; or

(2) prohibits a health carrier from:

(i) establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service through telehealth for which the health carrier does not already reimburse other health care providers for delivering the service through telehealth;

(ii) establishing reasonable medical management techniques, provided the criteria or techniques are not unduly burdensome or unreasonable for the particular service; or

(iii) requiring documentation or billing practices designed to protect the health carrier or patient from fraudulent claims, provided the practices are not unduly burdensome or unreasonable for the particular service.

(f) Nothing in this section requires the use of telehealth when a health care provider determines that the delivery of a health care service through telehealth is not appropriate or when an enrollee chooses not to receive a health care service through telehealth.

Subd. 4. **Parity between telehealth and in-person services.** (a) A health carrier must not restrict or deny coverage of a health care service that is covered under a health plan solely:

(1) because the health care service provided by the health care provider through telehealth is not provided through in-person contact; or

(2) based on the communication technology or application used to deliver the health care service through telehealth, provided the technology or application complies with this section and is appropriate for the particular service.

(b) Prior authorization may be required for health care services delivered through telehealth only if prior authorization is required before the delivery of the same service through in-person contact.

(c) A health carrier may require a utilization review for services delivered through telehealth, provided the utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for the same services delivered through in-person contact.

Subd. 5. **Reimbursement for services delivered through telehealth.** (a) A health carrier must reimburse the health care provider for services delivered through telehealth on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered by the health care provider through in-person contact.

(b) A health carrier must not deny or limit reimbursement based solely on a health care provider delivering the service or consultation through telehealth instead of through in-person contact.

(c) A health carrier must not deny or limit reimbursement based solely on the technology and equipment used by the health care provider to deliver the health care service or consultation through telehealth, provided the technology and equipment used by the provider meets the requirements of this section and is appropriate for the particular service.

Subd. 6. **Telehealth equipment.** (a) A health carrier must not require a health care provider to use specific telecommunications technology and equipment as a condition of coverage under this section, provided the health care provider uses telecommunications technology and equipment that complies with current industry interoperable standards and

complies with standards required under the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and regulations promulgated under that Act, unless authorized under this section.

(b) A health carrier must provide coverage for health care services delivered through telehealth by means of the use of audio-only telephone communication if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication.

Subd. 7. **Telemonitoring services.** A health carrier must provide coverage for telemonitoring services if:

(1) the telemonitoring service is medically appropriate based on the enrollee's medical condition or status;

(2) the enrollee is cognitively and physically capable of operating the monitoring device or equipment, or the enrollee has a caregiver who is willing and able to assist with the monitoring device or equipment; and

(3) the enrollee resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

Sec. 2. Minnesota Statutes 2020, section 147.033, is amended to read:

147.033 PRACTICE OF ~~TELEMEDICINE~~ TELEHEALTH.

Subdivision 1. **Definition.** For the purposes of this section, ~~"telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way interactive audio, and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, that facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.~~ "telehealth" has the meaning given in section 62A.673, subdivision 2, paragraph (h).

Subd. 2. **Physician-patient relationship.** A physician-patient relationship may be established through ~~telemedicine~~ telehealth.

Subd. 3. **Standards of practice and conduct.** A physician providing health care services by ~~telemedicine~~ telehealth in this state shall be held to the same standards of practice and conduct as provided in this chapter for in-person health care services.

Sec. 3. Minnesota Statutes 2020, section 151.37, subdivision 2, is amended to read:

Subd. 2. **Prescribing and filing.** (a) A licensed practitioner in the course of professional practice only, may prescribe, administer, and dispense a legend drug, and may cause the same to be administered by a nurse, a physician assistant, or medical student or resident under the practitioner's direction and supervision, and may cause a person who is an appropriately certified, registered, or licensed health care professional to prescribe, dispense, and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference to a specific patient, by directing a licensed dietitian or licensed nutritionist, pursuant to section 148.634; a nurse, pursuant to section 148.235, subdivisions 8 and 9; physician assistant; medical student or resident; or pharmacist according to section 151.01, subdivision 27, to adhere to a particular practice guideline or protocol when treating patients whose condition falls within such guideline or protocol, and when such guideline or protocol specifies the circumstances under which the legend drug is to be prescribed and administered. An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug. This paragraph applies to a physician assistant only if the physician assistant meets the requirements of ~~section 147A.18~~ sections 147A.02 and 147A.09.

(b) The commissioner of health, if a licensed practitioner, or a person designated by the commissioner who is a licensed practitioner, may prescribe a legend drug to an individual or by protocol for mass dispensing purposes where the commissioner finds that the conditions triggering section 144.4197 or 144.4198, subdivision 2, paragraph (b), exist. The commissioner, if a licensed practitioner, or a designated licensed practitioner, may prescribe, dispense, or administer a legend drug or other substance listed in subdivision 10 to control tuberculosis and other communicable diseases. The commissioner may modify state drug labeling requirements, and medical screening criteria and documentation, where time is critical and limited labeling and screening are most likely to ensure legend drugs reach the maximum number of persons in a timely fashion so as to reduce morbidity and mortality.

(c) A licensed practitioner that dispenses for profit a legend drug that is to be administered orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the practitioner's licensing board a statement indicating that the practitioner dispenses legend

drugs for profit, the general circumstances under which the practitioner dispenses for profit, and the types of legend drugs generally dispensed. It is unlawful to dispense legend drugs for profit after July 31, 1990, unless the statement has been filed with the appropriate licensing board. For purposes of this paragraph, "profit" means (1) any amount received by the practitioner in excess of the acquisition cost of a legend drug for legend drugs that are purchased in prepackaged form, or (2) any amount received by the practitioner in excess of the acquisition cost of a legend drug plus the cost of making the drug available if the legend drug requires compounding, packaging, or other treatment. The statement filed under this paragraph is public data under section 13.03. This paragraph does not apply to a licensed doctor of veterinary medicine or a registered pharmacist. Any person other than a licensed practitioner with the authority to prescribe, dispense, and administer a legend drug under paragraph (a) shall not dispense for profit. To dispense for profit does not include dispensing by a community health clinic when the profit from dispensing is used to meet operating expenses.

(d) A prescription drug order for the following drugs is not valid, unless it can be established that the prescription drug order was based on a documented patient evaluation, including an examination, adequate to establish a diagnosis and identify underlying conditions and contraindications to treatment:

(1) controlled substance drugs listed in section 152.02, subdivisions 3 to 5;

(2) drugs defined by the Board of Pharmacy as controlled substances under section 152.02, subdivisions 7, 8, and 12;

(3) muscle relaxants;

(4) centrally acting analgesics with opioid activity;

(5) drugs containing butalbital; or

(6) phosphodiesterase type 5 inhibitors when used to treat erectile dysfunction.

~~For purposes of prescribing drugs listed in clause (6), the requirement for a documented patient evaluation, including an examination, may be met through the use of telemedicine, as defined in section 147.033, subdivision 1.~~

(e) For the purposes of paragraph (d), the requirement for an examination shall be met if:

(1) an in-person examination has been completed in any of the following circumstances:

~~(1)~~ (i) the prescribing practitioner examines the patient at the time the prescription or drug order is issued;

~~(2)~~ (ii) the prescribing practitioner has performed a prior examination of the patient;

~~(3)~~ (iii) another prescribing practitioner practicing within the same group or clinic as the prescribing practitioner has examined the patient;

~~(4)~~ (iv) a consulting practitioner to whom the prescribing practitioner has referred the patient has examined the patient; or

~~(5)~~ (v) the referring practitioner has performed an examination in the case of a consultant practitioner issuing a prescription or drug order when providing services by means of telemedicine~~.~~; or

(2) the prescription order is for a drug listed in paragraph (d), clause (6), or for medication assisted therapy for a substance use disorder, and the prescribing practitioner has completed an examination of the patient via telehealth as defined in section 62A.673, subdivision 2, paragraph (h).

(f) Nothing in paragraph (d) or (e) prohibits a licensed practitioner from prescribing a drug through the use of a guideline or protocol pursuant to paragraph (a).

(g) Nothing in this chapter prohibits a licensed practitioner from issuing a prescription or dispensing a legend drug in accordance with the Expedited Partner Therapy in the Management of Sexually Transmitted Diseases guidance document issued by the United States Centers for Disease Control.

(h) Nothing in paragraph (d) or (e) limits prescription, administration, or dispensing of legend drugs through a public health clinic or other distribution mechanism approved by the commissioner of health or a community health board in order to prevent, mitigate, or treat a pandemic illness, infectious disease outbreak, or intentional or accidental release of a biological, chemical, or radiological agent.

(i) No pharmacist employed by, under contract to, or working for a pharmacy located within the state and licensed under section 151.19, subdivision 1, may dispense a legend drug based on a prescription that the pharmacist knows, or would reasonably be expected to know, is not valid under paragraph (d).

(j) No pharmacist employed by, under contract to, or working for a pharmacy located outside the state and licensed under section 151.19, subdivision 1, may dispense a legend drug to a resident of this state based on a prescription that the pharmacist knows, or would reasonably be expected to know, is not valid under paragraph (d).

(k) Nothing in this chapter prohibits the commissioner of health, if a licensed practitioner, or, if not a licensed practitioner, a designee of the commissioner who is a licensed practitioner, from prescribing legend drugs for field-delivered therapy in the treatment of a communicable disease according to the Centers For Disease Control and Prevention Partner Services Guidelines.

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

Sec. 4. Minnesota Statutes 2020, section 245G.01, subdivision 13, is amended to read:

Subd. 13. **Face-to-face.** "Face-to-face" means two-way, real-time, interactive ~~and visual~~ communication between a client and a treatment service provider and includes services delivered in person or via ~~telemedicine~~ telehealth with priority being given to interactive audio and visual communication, if available.

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

Sec. 5. Minnesota Statutes 2020, section 245G.01, subdivision 26, is amended to read:

Subd. 26. **~~Telemedicine~~ Telehealth.** ~~"Telemedicine"~~ "Telehealth" means the delivery of a substance use disorder treatment service while the client is at an originating site and the ~~licensed~~ health care provider is at a distant site via telehealth as defined in section 256B.0625, subdivision 3b, and as specified in section 254B.05, subdivision 5, paragraph (f).

Sec. 6. Minnesota Statutes 2020, section 245G.06, subdivision 1, is amended to read:

Subdivision 1. **General.** Each client must have a person-centered individual treatment plan developed by an alcohol and drug counselor within ten days from the day of service initiation for a residential program and within five calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. The individual treatment plan is developed upon the qualified staff member's dated signature. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition, the client's level of participation, and on whether methods

identified have the intended effect. A change to the plan must be signed by the client and the alcohol and drug counselor. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. If a client is receiving treatment services or an assessment via telehealth, the alcohol and drug counselor may document the client's verbal approval of the treatment plan or change to the treatment plan in lieu of the client's signature.

Sec. 7. Minnesota Statutes 2020, section 254A.19, subdivision 5, is amended to read:

Subd. 5. **Assessment via ~~telemedicine~~ telehealth.** Notwithstanding Minnesota Rules, part 9530.6615, subpart 3, item A, a chemical use assessment may be conducted via ~~telemedicine~~ telehealth as defined in section 256B.0625, subdivision 3b.

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

Sec. 8. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

(3) care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) medication-assisted therapy services that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(9) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(12) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the commissioner, to serve clients with the specific disabilities that the program is designed to serve;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via ~~two-way interactive video~~ telehealth as defined in section 256B.0625, subdivision 3b. The use of ~~two-way interactive video~~ telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. ~~The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.~~

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

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

Sec. 9. Minnesota Statutes 2020, section 256B.0596, is amended to read:

256B.0596 MENTAL HEALTH CASE MANAGEMENT.

Counties shall contract with eligible providers willing to provide mental health case management services under section 256B.0625, subdivision 20. In order to be eligible, in addition to general provider requirements under this chapter, the provider must:

(1) be willing to provide the mental health case management services; and

(2) have a minimum of at least one contact with the client per week, either in person or through telehealth, and at least one face-to-face in-person contact with the client every six months. This section is not intended to limit the ability of a county to provide its own mental health case management services.

Sec. 10. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, is amended to read:

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

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

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

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

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

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

(5) has an established quality assurance process related to ~~telemedicine~~ delivering services through telehealth.

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

(1) the type of service ~~provided by telemedicine~~ delivered through telehealth;

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

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

(4) the mode of transmission ~~of~~ used to deliver the ~~telemedicine~~ service through telehealth and records evidencing that a particular mode of transmission was utilized;

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

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

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

(d) For purposes of this subdivision, unless otherwise covered under this chapter~~,~~ ~~"telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.~~:

(1) "telehealth" means the delivery of health care services or consultations through the use of real-time, two-way interactive audio and visual or audio-only communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward transfers, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Unless interactive visual and audio communication is specifically required, telehealth includes audio-only communication between a health care provider and a patient, if the communication is a scheduled appointment with the health care provider and the standard of care for the service can be met through the use of audio-only communication. Telehealth does not include communication between health care providers or between a health care provider and a patient that consists solely of an e-mail or facsimile transmission.

Telehealth does not include communication between health care providers that consists solely of a telephone conversation;

~~(e) For purposes of this section, "licensed~~ (2) "health care provider" means a ~~licensed~~ health care provider ~~under section 62A.671, subdivision 6~~ as defined under section 62A.673, a community paramedic as defined under section 144E.001, subdivision 5f, ~~or a mental health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional, and~~ a community health worker who meets the criteria under subdivision 49, paragraph (a)~~; "health care provider" is defined under section 62A.671, subdivision 3;~~, a mental health certified peer specialist under section 256B.0615, subdivision 5, a mental health certified family peer specialist under section 256B.0616, subdivision 5, a mental health rehabilitation worker under section 256B.0623, subdivision 5, paragraph (a), clause (4), and paragraph (b), a mental health behavioral aide under section 256B.0943, subdivision 7, paragraph (b), clause (3), a treatment coordinator under section 245G.11, subdivision 7, an alcohol and drug counselor under section 245G.11, subdivision 5, a recovery peer under section 245G.11, subdivision 8, and a mental health case manager under section 245.462, subdivision 4; and

(3) "originating site" ~~is defined under section 62A.671, subdivision 7~~, "distant site," and "store-and-forward transfer" have the meanings given in section 62A.673, subdivision 2.

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

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

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

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

Sec. 11. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 3h. **Telemonitoring services.** (a) Medical assistance covers telemonitoring services if a recipient:

(1) has been diagnosed and is receiving services for at least one of the following chronic conditions: hypertension, cancer, congestive heart failure, chronic obstructive pulmonary disease, asthma, or diabetes;

(2) requires at least five times per week monitoring to manage the chronic condition, as ordered by the recipient's health care provider;

(3) has had two or more emergency room or inpatient hospitalization stays within the last 12 months due to the chronic condition or the recipient's health care provider has identified that telemonitoring services would likely prevent the recipient's admission or readmission to a hospital, emergency room, or nursing facility;

(4) is cognitively and physically capable of operating the monitoring device or equipment, or the recipient has a caregiver who is willing and able to assist with the monitoring device or equipment; and

(5) resides in a setting that is suitable for telemonitoring and not in a setting that has health care staff on site.

(b) For purposes of this subdivision, "telemonitoring services" means the remote monitoring of data related to a recipient's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a provider for analysis. The assessment and monitoring of the health data transmitted by telemonitoring must be performed by one of the following licensed health care professionals: physician, podiatrist, registered nurse, advanced practice registered nurse, physician assistant, respiratory therapist, or licensed professional working under the supervision of a medical director.

Sec. 12. Minnesota Statutes 2020, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance covers medication therapy management services for a recipient taking prescriptions to treat or prevent one or more chronic medical conditions. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan, which may include prescribing medications or products in accordance with section 151.37, subdivision 14, 15, or 16;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued by the Board of Pharmacy of the state in which the medication therapy management service is being performed;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements; and

~~(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, including long-term care settings, group homes, and facilities providing assisted living services, but excluding skilled nursing facilities; and~~

~~(4)~~ (3) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance providers. The

commissioner may also establish ~~contact requirements between the pharmacist and recipient, including limiting~~ limits on the number of reimbursable consultations per recipient.

(d) ~~If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide The~~ Medication therapy management services may be provided via ~~two-way interactive video~~ telehealth as defined in subdivision 3b and may be delivered into a patient's residence. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b)~~, and must be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3). The patient must also be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3). Services provided under this paragraph may not be transmitted into the patient's residence~~.

~~(e) Medication therapy management services may be delivered into a patient's residence via secure interactive video if the medication therapy management services are performed electronically during a covered home care visit by an enrolled provider. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b) and must be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3).~~

Sec. 13. Minnesota Statutes 2020, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the

provider must document at least a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 20b with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative or a contact by interactive video that meets the requirements of subdivision 20b; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 20b with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds

used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include the federal earnings, the state share, and the county share.

(m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(p) If the recipient is receiving care in a hospital, nursing facility, or residential setting licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week, mental health targeted case management services must actively support identification of community alternatives for the recipient and discharge planning.

Sec. 14. Minnesota Statutes 2020, section 256B.0625, subdivision 20b, is amended to read:

Subd. 20b. **Mental health targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan, taking into consideration the person's vulnerability and active personal relationships; and

(4) interactive video is used for up to~~, but not more than, 50 percent of the minimum required face-to-face~~ two consecutive contacts following each in-person contact, not to exceed 50 percent of the minimum required face-to-face contact.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;

(3) established protocols addressing how and when to discontinue interactive video services; and

(4) established a quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video:

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

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the person receiving case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized;

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

(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).

Sec. 15. Minnesota Statutes 2020, section 256B.0625, subdivision 46, is amended to read:

Subd. 46. **Mental health ~~telemedicine~~ telehealth.** ~~Effective January 1, 2006, and~~ Subject to federal approval, mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via ~~two-way interactive video~~ telehealth as defined in subdivision 3b. Use of ~~two-way interactive video~~ telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the service. ~~The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.~~

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

Sec. 16. Minnesota Statutes 2020, section 256B.0911, subdivision 1a, is amended to read:

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

(a) Until additional requirements apply under paragraph (b), "long-term care consultation services" means:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations for and referrals to cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) ~~face-to-face~~ long-term care consultation assessments conducted according to subdivision 3a, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) determination of home and community-based waiver and other service eligibility as required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on a long-term care consultation assessment and community support plan development, appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

(7) providing recommendations for institutional placement when there are no cost-effective community services available;

(8) providing access to assistance to transition people back to community settings after institutional admission;

(9) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Hub and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made. For the purposes of this subdivision, "competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an individual is compensated at or above the minimum wage, but not

less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities;

(10) providing information about independent living to ensure that an informed choice about independent living can be made; and

(11) providing information about self-directed services and supports, including self-directed funding options, to ensure that an informed choice about self-directed options can be made.

(b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c, and 3a, "long-term care consultation services" also means:

(1) service eligibility determination for the following state plan services:

(i) personal care assistance services under section 256B.0625, subdivisions 19a and 19c;

(ii) consumer support grants under section 256.476; or

(iii) community first services and supports under section 256B.85;

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, gaining access to:

(i) relocation targeted case management services available under section 256B.0621, subdivision 2, clause (4);

(ii) case management services targeted to vulnerable adults or developmental disabilities under section 256B.0924; and

(iii) case management services targeted to people with developmental disabilities under Minnesota Rules, part 9525.0016;

(3) determination of eligibility for semi-independent living services under section 252.275; and

(4) obtaining necessary diagnostic information to determine eligibility under clauses (2) and (3).

(c) "Long-term care options counseling" means the services provided by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(d) "Minnesota health care programs" means the medical assistance program under this chapter and the alternative care program under section 256B.0913.

(e) "Lead agencies" means counties administering or tribes and health plans under contract with the commissioner to administer long-term care consultation services.

(f) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives, the settings in which the person receives the services, and the setting in which the person lives.

(g) "Informed choice" means a voluntary choice of services, settings, living arrangement, and work by a person from all available service and setting options based on accurate and complete information concerning all available service and setting options and concerning the person's own preferences, abilities, goals, and objectives. In order for a person to make an informed choice, all available options must be developed and presented to the person in a way the person can understand to empower the person to make fully informed choices.

(h) "Available service and setting options" or "available options," with respect to the home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49, means all services and settings defined under the waiver plan for which a waiver applicant or waiver participant is eligible.

(i) "Independent living" means living in a setting that is not controlled by a provider.

Sec. 17. Minnesota Statutes 2020, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. ~~Face-to-face~~ Assessments must be conducted according to paragraphs (b) to ~~(i)~~ (q).

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, conversation-based, person-centered assessment.

The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a person-centered community support plan that meets the individual's needs and preferences.

(d) Except as provided in paragraph (q), the assessment must be conducted by a certified assessor in a face-to-face conversational interview with the person being assessed. The person's legal representative must provide input during the assessment process and may do so remotely if requested. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under chapter 256S, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs the person completed in consultation with someone who is known to the person and has interaction with the person on a regular basis. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

(e) The certified assessor and the individual responsible for developing the coordinated service and support plan must complete the community support plan and the coordinated service and support plan no more than 60 calendar days from the assessment visit. The person or the person's legal representative must be provided with a written community support plan within the timelines established by the commissioner, regardless of whether the person is eligible for Minnesota health care programs.

(f) For a person being assessed for elderly waiver services under chapter 256S, a provider who submitted information under paragraph (d) shall receive the final written community support plan when available and the Residential Services Workbook.

(g) The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including:

(i) all available options for case management services and providers;

(ii) all available options for employment services, settings, and providers;

(iii) all available options for living arrangements;

(iv) all available options for self-directed services and supports, including self-directed budget options; and

(v) service provided in a non-disability-specific setting;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(h) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(i) The person has the right to make the final decision:

(1) between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

(2) between community placement in a setting controlled by a provider and living independently in a setting not controlled by a provider;

(3) between day services and employment services; and

(4) regarding available options for self-directed services and supports, including self-directed funding options.

(j) The lead agency must give the person receiving long-term care consultation services or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section

256.045, subdivision 3. The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated; and

(10) documentation that available options for employment services, independent living, and self-directed services and supports were described to the individual.

(k) ~~Face-to-face~~ Assessment completed as part of an eligibility determination for multiple programs for the alternative care, elderly waiver, developmental disabilities, community access for disability inclusion, community alternative care, and brain injury waiver programs under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(l) The effective eligibility start date for programs in paragraph (k) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (k) cannot be prior to the date the most recent updated assessment is completed.

(m) If an eligibility update is completed within 90 days of the previous ~~face-to-face~~ assessment and documented in the department's Medicaid Management Information System (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date of the previous ~~face-to-face~~ assessment when all other eligibility requirements are met.

(n) At the time of reassessment, the certified assessor shall assess each person receiving waiver residential supports and services currently residing in a community residential setting, licensed adult foster care home that is either not the primary residence of the license holder or in which the license holder is not the primary caregiver, family adult foster care residence, customized living setting, or supervised living facility to determine if that person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23, in a setting not controlled by a provider, or to receive integrated community supports as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified assessor shall offer the person, through a person-centered planning process, the option to receive alternative housing and service options.

(o) At the time of reassessment, the certified assessor shall assess each person receiving waiver day services to determine if that person would prefer to receive employment services as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified

assessor shall describe to the person through a person-centered planning process the option to receive employment services.

(p) At the time of reassessment, the certified assessor shall assess each person receiving non-self-directed waiver services to determine if that person would prefer an available service and setting option that would permit self-directed services and supports. The certified assessor shall describe to the person through a person-centered planning process the option to receive self-directed services and supports.

(q) All assessments performed according to this subdivision must be face-to-face unless the assessment is a reassessment meeting the requirements of this paragraph. Subject to federal approval, remote reassessments conducted by interactive video or telephone may substitute for face-to-face reassessments for services provided by alternative care under section 256B.0913, the elderly waiver under chapter 256S, the developmental disabilities waiver under section 256B.092, and the community access for disability inclusion, community alternative care, and brain injury waiver programs under section 256B.49. Remote reassessments may be substituted for two consecutive reassessments if followed by a face-to-face reassessment. A remote reassessment is permitted only if the person being reassessed, the person's legal representative, and the lead agency case manager all agree that there is no change in the person's condition, there is no need for a change in service, and that a remote reassessment is appropriate. The person being reassessed, or the person's legal representative, has the right to refuse a remote reassessment at any time. During a remote reassessment, if the certified assessor determines in the assessor's sole judgment that a remote reassessment is inappropriate, the certified assessor shall suspend the remote reassessment and schedule a face-to-face reassessment to complete the reassessment. All other requirements of a face-to-face reassessment apply to a remote reassessment.

Sec. 18. Minnesota Statutes 2020, section 256B.0911, subdivision 3f, is amended to read:

Subd. 3f. **Long-term care reassessments and community support plan updates.** (a) Prior to a ~~face-to-face~~ reassessment, the certified assessor must review the person's most recent assessment. Reassessments must be tailored using the professional judgment of the assessor to the person's known needs, strengths, preferences, and circumstances. Reassessments provide information to support the person's informed choice and opportunities to express choice regarding activities that contribute to quality of life, as well as information and opportunity to identify goals related to desired employment, community activities, and preferred living environment. Reassessments require a review of the most recent assessment, review of the current coordinated service and support plan's effectiveness, monitoring of

services, and the development of an updated person-centered community support plan. Reassessments must verify continued eligibility, offer alternatives as warranted, and provide an opportunity for quality assurance of service delivery. ~~Face-to-face~~ Reassessments must be conducted annually or as required by federal and state laws and rules. For reassessments, the certified assessor and the individual responsible for developing the coordinated service and support plan must ensure the continuity of care for the person receiving services and complete the updated community support plan and the updated coordinated service and support plan no more than 60 days from the reassessment visit.

(b) The commissioner shall develop mechanisms for providers and case managers to share information with the assessor to facilitate a reassessment and support planning process tailored to the person's current needs and preferences.

Sec. 19. Minnesota Statutes 2020, section 256B.0911, subdivision 4d, is amended to read:

Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing facility must be screened prior to admission according to the requirements outlined in section 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as required under section 256.975, subdivision 7.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within the timeline established by the commissioner, based on review of data.

(d) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3b.

(e) For individuals under 21 years of age, a screening interview which recommends nursing facility admission must be face-to-face and approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the Senior LinkAge Line must be notified of the admission on the

next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within the timeline established by the commissioner, based on review of data.

(g) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options, including consumer-directed options, so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

(h) An individual under 65 years of age residing in a nursing facility shall receive a ~~face-to-face assessment~~ reassessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a ~~face-to-face assessment~~ reassessment at least once every 36 months for the same purposes. A remote reassessment is permitted only if the person being reassessed, the person's legal representative, and the lead agency case manager all agree that there is no change in the person's condition, there is no need for a change in service, and that a remote reassessment is appropriate. The person being reassessed, or the person's legal representative, has the right to refuse a remote reassessment at any time. During a remote reassessment, if the certified assessor determines in the assessor's sole judgment that a remote reassessment is inappropriate, the certified assessor shall suspend the remote reassessment and schedule a face-to-face reassessment to complete the reassessment. All other requirements of a face-to-face reassessment apply to a remote reassessment.

(i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for ~~face-to-face~~ assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

(j) Funding for preadmission screening follow-up shall be provided to the Disability Hub for the under-60 population by the Department of Human Services to cover options counseling salaries and expenses to provide the services described in subdivisions 7a to 7c. The Disability Hub shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening follow-up services and shall seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (aa).

Sec. 20. Minnesota Statutes 2020, section 256B.0924, subdivision 4a, is amended to read:

Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment under subdivision 6 if:

(1) the person receiving targeted case management services is residing in:

(i) a hospital;

(ii) a nursing facility; or

(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;

(2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;

(3) the use of interactive video is approved as part of the person's written personal service or case plan; and

(4) interactive video is used for up to~~, but not more than, 50 percent of the minimum required face-to-face~~ two consecutive contacts following each in-person contact, not to exceed 50 percent of the minimum required face-to-face contact.

(b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.

(c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:

(1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;

(2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;

(3) established protocols addressing how and when to discontinue interactive video services; and

(4) established a quality assurance process related to interactive video services.

(d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video:

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

(2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the person receiving case management services;

(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized;

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

(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).

Sec. 21. Minnesota Statutes 2020, section 256B.0924, subdivision 6, is amended to read:

Subd. 6. **Payment for targeted case management.** (a) Medical assistance and MinnesotaCare payment for targeted case management shall be made on a monthly basis. In order to receive payment for an eligible adult, the provider must document at least one contact per month and not more than two consecutive months without a face-to-face contact or a contact by interactive video that meets the requirements of subdivision 4a with the adult or the adult's legal representative, family, primary caregiver, or other relevant persons identified as necessary to the development or implementation of the goals of the personal service plan.

(b) Payment for targeted case management provided by county staff under this subdivision shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of December 31, 2001. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

(c) Payment for targeted case management provided by county-contracted vendors shall be based on a monthly rate negotiated by the host county. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county may negotiate a team rate with a

vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

(d) If the service is provided by a team that includes contracted vendors and county staff, the costs for county staff participation on the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, the county must document, in the recipient's file, the need for team targeted case management and a description of the different roles of the team members.

(e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for targeted case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds.

(f) The commissioner may suspend, reduce, or terminate reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal disallowances. The county may share this responsibility with its contracted vendors.

(g) The commissioner shall set aside five percent of the federal funds received under this section for use in reimbursing the state for costs of developing and implementing this section.

(h) Payments to counties for targeted case management expenditures under this section shall only be made from federal earnings from services provided under this section. Payments to contracted vendors shall include both the federal earnings and the county share.

(i) Notwithstanding section 256B.041, county payments for the cost of case management services provided by county staff shall not be made to the commissioner of management and budget. For the purposes of targeted case management services provided by county staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

(j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for targeted case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(k) Payment for targeted case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

(l) Any growth in targeted case management services and cost increases under this section shall be the responsibility of the counties.

Sec. 22. Minnesota Statutes 2020, section 256B.094, subdivision 6, is amended to read:

Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical assistance reimbursement for services under this section shall be made on a monthly basis. Payment is based on face-to-face or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. These contacts must meet the minimum standards in clauses (1) and (2):

(1) there must be a face-to-face contact at least once a month except as provided in clause (2); and

(2) for a client placed outside of the county of financial responsibility, or a client served by tribal social services placed outside the reservation, in an excluded time facility under section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of Children, section 260.93, and the placement in either case is more than 60 miles beyond the county or reservation boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face contact.

Face-to-face contacts under this paragraph may be conducted using interactive video for up to two consecutive contacts following each in-person contact.

(b) Except as provided under paragraph (c), the payment rate is established using time study data on activities of provider service staff and reports required under sections 245.482 and 256.01, subdivision 2, paragraph (p).

(c) Payments for tribes may be made according to section 256B.0625 or other relevant federally approved rate setting methodology for child welfare targeted case management provided by Indian health services and facilities operated by a tribe or tribal organization.

(d) Payment for case management provided by county or tribal social services contracted vendors shall be based on a monthly rate negotiated by the host county or tribal social

services. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribal social services may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribal social services, except to reimburse the county or tribal social services for advance funding provided by the county or tribal social services to the vendor.

(e) If the service is provided by a team that includes contracted vendors and county or tribal social services staff, the costs for county or tribal social services staff participation in the team shall be included in the rate for county or tribal social services provided services. In this case, the contracted vendor and the county or tribal social services may each receive separate payment for services provided by each entity in the same month. To prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles and services of the team members.

(f) Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study, or under paragraph (c), shall be distributed according to earnings, to counties, reservations, or groups of counties or reservations which have the same payment rate under this subdivision, and to the group of counties or reservations which are not certified providers under section 256F.10. The commissioner shall modify the requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.

Sec. 23. Minnesota Statutes 2020, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only ~~face-to-face~~ assessments conducted according

to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

(d) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

Sec. 24. Minnesota Statutes 2020, section 256J.09, subdivision 3, is amended to read:

Subd. 3. **Submitting application form.** (a) A county agency must offer, in person or by mail, the application forms prescribed by the commissioner as soon as a person makes a written or oral inquiry. At that time, the county agency must:

(1) inform the person that assistance begins ~~with~~ on the date that the ~~signed~~ application is received by the county agency either as a written application; an application submitted by telephone; or an application submitted through Internet telepresence; or on the date that all eligibility criteria are met, whichever is later;

(2) inform a person that the person may submit the application by telephone or through Internet telepresence;

(3) inform a person that when the person submits the application by telephone or through Internet telepresence, the county agency must receive a signed written application within 30 days of the date that the person submitted the application by telephone or through Internet telepresence;

(4) inform the person that any delay in submitting the application will reduce the amount of assistance paid for the month of application;

~~(3)~~ (5) inform a person that the person may submit the application before an interview;

~~(4)~~ (6) explain the information that will be verified during the application process by the county agency as provided in section 256J.32;

~~(5)~~ (7) inform a person about the county agency's average application processing time and explain how the application will be processed under subdivision 5;

~~(6)~~ (8) explain how to contact the county agency if a person's application information changes and how to withdraw the application;

~~(7)~~ (9) inform a person that the next step in the application process is an interview and what a person must do if the application is approved including, but not limited to, attending

orientation under section 256J.45 and complying with employment and training services requirements in sections 256J.515 to 256J.57;

~~(8)~~ (10) inform the person that ~~the~~ an interview must be conducted. The interview may be conducted face-to-face in the county office or at a location mutually agreed upon, through Internet telepresence, or ~~at a location mutually agreed upon~~ by telephone;

~~(9) inform a person who has received MFIP or DWP in the past 12 months of the option to have a face-to-face, Internet telepresence, or telephone interview;~~

~~(10)~~ (11) explain the child care and transportation services that are available under paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

~~(11)~~ (12) identify any language barriers and arrange for translation assistance during appointments, including, but not limited to, screening under subdivision 3a, orientation under section 256J.45, and assessment under section 256J.521.

(b) Upon receipt of a signed application, the county agency must stamp the date of receipt on the face of the application. The county agency must process the application within the time period required under subdivision 5. An applicant may withdraw the application at any time by giving written or oral notice to the county agency. The county agency must issue a written notice confirming the withdrawal. The notice must inform the applicant of the county agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a county agency, in writing, that the applicant does not wish to withdraw the application, the county agency must reinstate the application and finish processing the application.

(c) Upon a participant's request, the county agency must arrange for transportation and child care or reimburse the participant for transportation and child care expenses necessary to enable participants to attend the screening under subdivision 3a and orientation under section 256J.45.

Sec. 25. Minnesota Statutes 2020, section 256J.45, subdivision 1, is amended to read:

Subdivision 1. **County agency to provide orientation.** A county agency must provide ~~a face-to-face~~ an orientation to each MFIP caregiver unless the caregiver is:

(1) a single parent, or one parent in a two-parent family, employed at least 35 hours per week; or

(2) a second parent in a two-parent family who is employed for 20 or more hours per week provided the first parent is employed at least 35 hours per week.

The county agency must inform caregivers who are not exempt under clause (1) or (2) that failure to attend the orientation is considered an occurrence of noncompliance with program requirements, and will result in the imposition of a sanction under section 256J.46. If the client complies with the orientation requirement prior to the first day of the month in which the grant reduction is proposed to occur, the orientation sanction shall be lifted.

Sec. 26. Minnesota Statutes 2020, section 256S.05, subdivision 2, is amended to read:

Subd. 2. **Nursing facility level of care determination required.** Notwithstanding other assessments identified in section 144.0724, subdivision 4, only ~~face-to-face~~ assessments conducted according to section 256B.0911, subdivisions 3, 3a, and 3b, that result in a nursing facility level of care determination at initial and subsequent assessments shall be accepted for purposes of a participant's initial and ongoing participation in the elderly waiver and a service provider's access to service payments under this chapter.

Sec. 27. **STUDY OF TELEHEALTH.**

(a) The commissioner of human services, consultation with the commissioners of health and commerce, shall study the impact of telehealth payment methodologies and expansion under this act on the coverage and provision of telehealth services under public health care programs and private health insurance. The study shall review and make recommendations related to:

(1) the impact of telehealth payment methodologies and expansion on access to health care services, quality of care, and value-based payments and innovation in care delivery;

(2) the short-term and long-term impacts of telehealth payment methodologies and expansion in reducing health care disparities and providing equitable access for underserved communities; and

(3) the use of audio-only communication in supporting equitable access to health care services, including behavioral health services for the elderly, rural communities, and communities of color, and eliminating barriers for vulnerable and underserved populations.

(b) In conducting the study, the commissioner shall consult with stakeholders and communities impacted by telehealth payment and expansion. The commissioner, notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, may use data available under that section to conduct the study. The commissioner shall report findings to the chairs

and ranking minority members of the legislative committees with jurisdiction over health care policy and finance and commerce, by February 15, 2023.

Sec. 28. **EFFECTIVE DATE.**

The amendments in this article to, or establishing, the following provisions of Minnesota Statutes are effective January 1, 2022: 245G.01, subdivision 26; 245G.06, subdivision 1; 256B.0596; and 256B.0625, subdivisions 3h and 13h.

Sec. 29. **EXPIRATION DATE.**

(a) The amendments in this article to, or establishing, the following provisions of Minnesota Statutes expire July 1, 2023: 245G.01, subdivision 13; 245G.01, subdivision 26; 245G.06, subdivision 1; 254A.19, subdivision 5; 254B.05, subdivision 5; 256B.0596; and 256B.0625, subdivisions 3b, 3h, 13h, and 46.

(b) Notwithstanding paragraph (a), the definition of "originating site" in Minnesota Statutes, section 256B.0625, subdivision 3b, paragraph (d), clause (3) shall not expire.

Sec. 30. **REVISOR INSTRUCTION.**

In Minnesota Statutes and Minnesota Rules, the revisor of statutes shall substitute the term "telemedicine" with "telehealth" whenever the term appears and substitute Minnesota Statutes, section 62A.673, whenever references to Minnesota Statutes, sections 62A.67, 62A.671, and 62A.672 appear.

Sec. 31. **REPEALER.**

Minnesota Statutes 2020, sections 62A.67; 62A.671; and 62A.672, are repealed.

ARTICLE 8

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2022" and "2023" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2022, or June 30, 2023, respectively. "The first year" is fiscal year 2022. "The second year" is fiscal year 2023. "The biennium" is fiscal years 2022 and 2023.

APPROPRIATIONS

Available for the Year

Ending June 30

2022 **2023**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ 8,945,179,000 $ 9,427,045,000**

Appropriations by Fund

	2022	2023
General	7,786,587,000	8,293,393,000
State Government Special Revenue	4,299,000	4,299,000
Health Care Access	867,214,000	845,520,000
Federal TANF	282,623,000	278,803,000
Lottery Prize	1,896,000	1,896,000
Opiate Epidemic Response	2,560,000	2,560,000

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

Subd. 2. **TANF Maintenance of Effort**

(a) **Nonfederal Expenditures.** The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF/MOE requirements, the commissioner may report as TANF/MOE expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) **Nonfederal Expenditures; Reporting.** For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) **Certain Expenditures Required.** The commissioner shall ensure that the MOE used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) **Limitation; Exceptions.** The commissioner must not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

(e) **Supplemental Expenditures.** For the purposes of paragraph (d), the commissioner may supplement the MOE claim with working

family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(f) **Reduction of Appropriations; Exception.** The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(g) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(h) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers

necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

(i) **Federal SNAP Education and Training Grants.** Federal funds available during fiscal years 2022 and 2023 for Supplemental Nutrition Assistance Program Education and Training and SNAP Quality Control Performance Bonus grants are appropriated to the commissioner of human services for the purposes allowable under the terms of the federal award. This paragraph is effective the day following final enactment.

Subd. 3. **Information Technology**

(a) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(b) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner

of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

Subd. 4. **Central Office; Operations**

	Appropriations by Fund	
General	174,084,000	167,528,000
State Government Special Revenue	4,174,000	4,174,000
Health Care Access	16,966,000	16,966,000
Federal TANF	100,000	100,000

(a) **Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Background Studies.** (1) $2,074,000 in fiscal year 2022 is from the general fund to provide a credit to providers who paid for emergency background studies in NETStudy 2.0.

(2) $2,061,000 in fiscal year 2022 is from the general fund to cover the costs of reprocessing emergency studies conducted under interagency agreements with other agencies.

(c) **Personal Care Assistance Compensation for Services Provided by a Parent or Spouse.** $349,000 in fiscal year 2022 is from the general fund for compensation for personal care assistance services provided by a parent or spouse under Laws 2020, Fifth Special Session chapter 3, article 10, section 3, as amended.

(d) **Family Foster Setting Background Studies.** $338,000 in fiscal year 2022 and $349,000 in fiscal year 2023 are from the general fund for costs related to implementing and administering licensed family foster setting background study requirements.

(e) **Cultural and Ethnic Communities Leadership Council.** $18,000 in fiscal year 2022 and $62,000 in fiscal year 2023 are from the general fund for the Cultural and Ethnic Communities Leadership Council.

(f) **Base Level Adjustment.** The general fund base is $162,024,000 in fiscal year 2024 and $162,255,000 in fiscal year 2025.

Subd. 5. **Central Office; Children and Families**

	Appropriations by Fund	
General	18,435,000	18,402,000
Federal TANF	2,582,000	2,582,000

(a) **Financial Institution Data Match and Payment of Fees.** The commissioner is authorized to allocate up to $310,000 each year in fiscal year 2022 and fiscal year 2023 from the systems special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

(b) **Base Level Adjustment.** The general fund base is $18,692,000 in fiscal year 2024 and $18,692,000 in fiscal year 2025.

Subd. 6. **Central Office; Health Care**

	Appropriations by Fund	
General	25,546,000	23,557,000
Health Care Access	28,168,000	28,168,000

(a) **Case Management Benefit Study for American Indians.** $200,000 in fiscal year 2022 is from the general fund for a contract to conduct fiscal analysis and development of standards for a targeted case management benefit for American Indians. The commissioner of human services must consult the Minnesota Indian Affairs Council in the development of any request for proposal and in the evaluation of responses. This is a onetime appropriation. Any unencumbered balance remaining from the first year does not

cancel and is available for the second year of the biennium.

(b) **Integrated Care for High-Risk Pregnant Women Grant Program.** $106,000 in fiscal year 2022 and $122,000 in fiscal year 2023 are from the general fund for administration of the integrated care for high-risk pregnant women grant program under Minnesota Statutes, section 256B.79.

(c) **Studies on Health Care Delivery.** $700,000 in fiscal year 2022 and $300,000 in fiscal year 2023 are from the general fund for the commissioner of human services to develop a legislative proposal for a public option program and to compare and report to the legislature on delivery and payment system models to deliver services to MinnesotaCare enrollees and certain medical assistance enrollees.

(d) **Base Level Adjustment.** The general fund base is $24,036,000 in fiscal year 2024 and $24,004,000 in fiscal year 2025.

Subd. 7. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	18,873,000	18,786,000
State Government Special Revenue	125,000	125,000

(a) **Assisted Living Survey.** $2,593,000 in fiscal year 2022 and $2,593,000 in fiscal year 2023 are from the general fund for development and administration of a resident experience survey and family survey for all assisted living facilities according to Minnesota Statutes, section 256B.439,

subdivision 3c. These appropriations are available in either year of the biennium.

(b) **Base Level Adjustment.** The general fund base is $18,830,000 in fiscal year 2024 and $18,900,000 in fiscal year 2025.

Subd. 8. **Central Office; Community Supports**

	Appropriations by Fund	
General	35,653,000	35,223,000
Lottery Prize	163,000	163,000
Opioid Epidemic Response	60,000	60,000

(a) **Study of Self Directed Tiered Wage Structure.** $25,000 in fiscal year 2022 is from the general fund for a study of the feasibility of a tiered wage structure for individual providers. This is a onetime appropriation. This appropriation is available only if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

(b) **Substance Use Disorder Treatment Paperwork Reduction.** $200,000 in fiscal year 2022 and $118,000 in fiscal year 2023 are from the general fund for a contract with a vendor to develop, assess, and recommend systems improvements to minimize regulatory paperwork and improve systems for licensed substance use disorder programs. This is a onetime appropriation.

(c) **Case Management and Substance Use Disorder Treatment Rate Methodology Analysis.** $500,000 in fiscal year 2022 and $200,000 in fiscal year 2023 are from the

general fund for the fiscal analysis needed to establish federally compliant payment methodologies for all medical assistance-funded case management services, including substance use disorder treatment rates. This is a onetime appropriation.

(d) **Substance Use Disorder Community of Practice.** $250,000 in fiscal year 2022 and $250,000 in fiscal year 2023 are from the general fund for the commissioner of human services to establish and administer the substance use disorder community of practice, including providing compensation for community of practice participants.

(e) **Sober Housing Program Recommendations Development.** $90,000 in fiscal year 2022 is from the general fund for developing recommendations related to sober housing programs and completing and submitting a report on the recommendations to the legislature.

(f) **Base Level Adjustment.** The general fund base is $34,634,000 in fiscal year 2024 and $34,666,000 in fiscal year 2025. The opiate epidemic response fund base is $60,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 9. **Forecasted Programs; MFIP/DWP**

Appropriations by Fund		
General	92,588,000	91,668,000
Federal TANF	104,285,000	104,410,000

Subd. 10. **Forecasted Programs; MFIP Child Care Assistance.**	146,000	569,000
Subd. 11. **Forecasted Programs; General Assistance.**	53,574,000	52,835,000

(a) **General Assistance Standard.** The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

(b) **Emergency General Assistance Limit.** The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2022 and $6,729,812 in fiscal year 2023. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

Subd. 12. **Forecasted Programs; Minnesota Supplemental Aid** 51,779,000 52,486,000

Subd. 13. **Forecasted Programs; Housing Support** 184,005,000 191,966,000

Subd. 14. **Forecasted Programs; Northstar Care for Children** 110,583,000 121,246,000

Subd. 15. **Forecasted Programs; MinnesotaCare** 207,437,000 184,822,000

Generally. This appropriation is from the health care access fund.

Subd. 16. **Forecasted Programs; Medical Assistance**

Appropriations by Fund		
General	6,058,941,000	6,561,264,000
Health Care Access	611,178,000	612,099,000

Behavioral Health Services. $1,000,000 in fiscal year 2022 and $1,000,000 in fiscal year 2023 are for behavioral health services provided by hospitals identified under

Minnesota Statutes, section 256.969, subdivision 2b, paragraph (a), clause (4). The increase in payments shall be made by increasing the adjustment under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (e), clause (2).

Subd. 17. **Forecasted Programs; Alternative Care** 45,669,000 45,656,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 18. **Forecasted Programs; Behavioral Health Fund** 132,377,000 116,706,000

(a) **Grants to Tribal Governments.** $28,873,377 in fiscal year 2022 is from the general fund to satisfy the value of overpayments owed by the Leech Lake Band of Ojibwe and White Earth Band of Chippewa to repay overpayments for medication-assisted treatment services between fiscal year 2014 and fiscal year 2019. The grant to the Leech Lake Band of Ojibwe shall be $14,666,122 and the grant to the White Earth Band of Chippewa shall be $14,207,215. This is a onetime appropriation.

(b) **Institutions for Mental Disease Payments.** $8,328,000 in fiscal year 2022 is from the general fund for the commissioner of human services to reimburse counties for the amount identified by the commissioner for the statewide county share of costs for which federal funds were claimed, but were not eligible for federal funding for substance use

disorder services provided in institutions for mental disease, for claims paid between January 1, 2014, and June 30, 2019. The commissioner of human services shall allocate this appropriation between counties in the amount identified by the department that is owed by each county. Prior to a county receiving reimbursement, the county must pay in full any unpaid consolidated chemical dependency treatment fund invoiced county share. This is a onetime appropriation.

Subd. 19. **Grant Programs; Support Services Grants**

	Appropriations by Fund	
General	8,715,000	8,715,000
Federal TANF	96,312,000	96,311,000

Subd. 20. **Grant Programs; BSF Child Care Grants.** (17,000) (23,000)

Subd. 21. **Grant Programs; Child Support Enforcement Grants** 50,000 50,000

Subd. 22. **Grant Programs; Children's Services Grants**

	Appropriations by Fund	
General	52,133,000	51,848,000
Federal TANF	140,000	140,000

(a) **Title IV-E Adoption Assistance.** (1) The commissioner shall allocate funds from the Title IV-E reimbursement to the state from the Fostering Connections to Success and Increasing Adoptions Act for adoptive, foster, and kinship families as required in Minnesota Statutes, section 256N.261.

(2) Additional federal reimbursement to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's

expanded eligibility for title IV-E adoption assistance is for postadoption, foster care, adoption, and kinship services, including a parent-to-parent support network.

(b) **Indian Child Welfare Training.** $1,012,000 in fiscal year 2022 and $993,000 in fiscal year 2023 are from the general fund for the establishment and operation of the Tribal Training and Certification Partnership at the University of Minnesota-Duluth to provide training, establish federal Indian Child Welfare Act and Minnesota Family Preservation Act training requirements for county child welfare workers, and develop Indigenous child welfare training for American Indian Tribes. The base for this appropriation is $1,053,000 in fiscal year 2024 and $1,053,000 in fiscal year 2025.

(c) **Parent Support for Better Outcomes Grants.** $150,000 in fiscal year 2022 and $150,000 in fiscal year 2023 are from the general fund for grants to Minnesota One-Stop for Communities to provide mentoring, guidance, and support services to parents navigating the child welfare system in Minnesota, in order to promote the development of safe, stable, and healthy families. Grant money may be used for parent mentoring, peer-to-peer support groups, housing support services, training, staffing, and administrative costs.

Subd. 23. **Grant Programs; Children and Community Service Grants**	60,251,000	60,856,000
Subd. 24. **Grant Programs; Children and Economic Support Grants**	34,240,000	34,240,000

(a) **Minnesota Food Assistance Program.** Unexpended funds for the Minnesota food assistance program for fiscal year 2022 do not cancel but are available for this purpose in fiscal year 2023.

(b) **Emergency Shelters.** $2,500,000 in fiscal year 2022 and $2,500,000 in fiscal year 2023 are for short-term housing facilities to increase the supply and improve the condition of shelters for individuals and families without a permanent residence. The commissioner shall ensure that a portion of the funds are expended to provide for short-term housing facilities for tribes and shall ensure equitable geographic distribution of funds. This appropriation is available until June 30, 2026.

(c) **Emergency Services Grants.** $9,000,000 in fiscal year 2022 and $9,000,000 in fiscal year 2023 are to provide emergency services grants under Minnesota Statutes, section 256E.36.

Subd. 25. **Grant Programs; Health Care Grants**

	Appropriations by Fund	
General	4,811,000	4,811,000
Health Care Access	3,465,000	3,465,000

Integrated Care for High Risk Pregnancies Initiative. $1,100,000 in fiscal year 2022 and $1,100,000 in fiscal year 2023 are from the general fund for the commissioner of human services to enter into a contract with the Integrated Care for High Risk Pregnancies (ICHRP) initiative to provide support to the integrated care for high-risk pregnant women grant program under Minnesota Statutes, section 256B.79.

Subd. 26. **Grant Programs; Other Long-Term Care Grants**	1,925,000	1,925,000
Subd. 27. **Grant Programs; Aging and Adult Services Grants**	32,495,000	32,495,000
Subd. 28. **Grant Programs; Deaf and Hard-of-Hearing Grants**	2,886,000	2,886,000
Subd. 29. **Grant Programs; Disabilities Grants**	20,251,000	18,863,000

Training Stipends for Direct Support Services Providers. $1,000,000 in fiscal year 2022 is from the general fund for stipends for individual providers of direct support services as defined in Minnesota Statutes, section 256B.0711, subdivision 1. These stipends are available to individual providers who have completed designated voluntary trainings made available through the State-Provider Cooperation Committee formed by the State of Minnesota and the Service Employees International Union Healthcare Minnesota. Any unspent appropriation in fiscal year 2022 is available in fiscal year 2023. This is a onetime appropriation. This appropriation is available only if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

Subd. 30. **Grant Programs; Housing Support Grants**	11,364,000	11,364,000

Long-Term Homeless Supportive Services. $1,000,000 in fiscal year 2022 and $1,000,000 in fiscal year 2023 are for long-term homeless supportive services under Minnesota Statutes, section 256K.26.

Subd. 31. **Grant Programs; Adult Mental Health Grants**

	Appropriations by Fund	
General	84,073,000	84,074,000
Opiate Epidemic Response	2,000,000	2,000,000

(a) **Culturally and Linguistically Appropriate Services Implementation Grants.** $750,000 in fiscal year 2022 and $750,000 in fiscal year 2023 are from the general fund for grants to substance use disorder treatment providers to implement culturally and linguistically appropriate services standards, according to the implementation and transition plan developed by the commissioner. This is a onetime appropriation.

(b) **Base Level Adjustment.** The general fund base is $82,324,000 in fiscal year 2024 and $82,324,000 in fiscal year 2025. The opiate epidemic response fund base is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 32. **Grant Programs; Child Mental Health Grants** 28,703,000 28,703,000

Base Level Adjustment. The general fund base is $28,726,000 in fiscal year 2024 and $28,726,000 in fiscal year 2025.

Subd. 33. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	2,809,000	2,806,000
Lottery Prize	1,733,000	1,733,000
Opiate Epidemic Response	500,000	500,000

(a) **Problem Gambling.** $225,000 in fiscal year 2022 and $225,000 in fiscal year 2023

are from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

(b) **Recovery Community Organization Grants.** $536,000 in fiscal year 2022 and $532,000 in fiscal year 2023 are from the general fund for grants to recovery community organizations, as defined in Minnesota Statutes, section 254B.01, subdivision 8, to provide for costs and community-based peer recovery support services that are not otherwise eligible for reimbursement under Minnesota Statutes, section 254B.05, as part of the continuum of care for substance use disorders.

(c) **Base Level Adjustment.** The general fund base is $2,636,000 in fiscal year 2024 and $2,636,000 in fiscal year 2025. The opiate epidemic response fund base is $500,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 34. **Direct Care and Treatment - Generally**

Transfer Authority. Money appropriated to budget activities under this subdivision and subdivisions 33 to 37, may be transferred between budget activities and between years of the biennium with the approval of the commissioner of management and budget.

Subd. 35. **Direct Care and Treatment - Mental Health and Substance Abuse** 139,946,000 144,103,000

(a) **Transfer Authority.** Money appropriated to support the continued operations of the Community Addiction Recovery Enterprise (C.A.R.E.) program may be transferred to the enterprise fund for C.A.R.E.

(b) **Operating Adjustment.** $2,307,000 in fiscal year 2022 and $2,453,000 in fiscal year 2023 are for the Community Addiction Recovery Enterprise program. The commissioner may transfer $2,307,000 in fiscal year 2022 and $2,453,000 in fiscal year 2023 to the enterprise fund for Community Addiction Recovery Enterprise.

Subd. 36. **Direct Care and Treatment - Community-Based Services** 18,771,000 19,752,000

(a) **Transfer Authority.** Money appropriated to support the continued operations of the Minnesota State Operated Community Services (MSOCS) program may be transferred to the enterprise fund for MSOCS.

(b) **Operating Adjustment.** $1,519,000 in fiscal year 2022 and $2,541,000 in fiscal year 2023 are for the Minnesota State Operated Community Services program. The commissioner may transfer $1,519,000 in fiscal year 2022 and $2,541,000 in fiscal year 2023 to the enterprise fund for Minnesota State Operated Community Services.

Subd. 37. **Direct Care and Treatment - Forensic Services** 119,854,000 122,206,000

Subd. 38. **Direct Care and Treatment - Sex Offender Program** 97,570,000 99,917,000

Transfer Authority. Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

Subd. 39. **Direct Care and Treatment - Operations** 63,504,000 65,910,000

Subd. 40. **Technical Activities** 79,204,000 78,260,000

(a) **Generally.** This appropriation is from the federal TANF fund.

(b) **Base Level Adjustment.** The TANF fund base is $71,493,000 in fiscal year 2024 and $71,493,000 in fiscal year 2025.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ 255,530,000 $ 251,781,000**

Appropriations by Fund

	2022	2023
General	152,494,000	150,454,000
State Government Special Revenue	54,465,000	53,356,000
Health Care Access	36,858,000	36,258,000
Federal TANF	11,713,000	11,713,000

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

Subd. 2. **Health Improvement**

Appropriations by Fund

General	114,297,000	112,692,000
State Government Special Revenue	9,103,000	7,777,000
Health Care Access	36,858,000	36,258,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 in fiscal year 2022 and $3,579,000 in fiscal year

2023 are from the TANF fund for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2022 and $4,978,000 in fiscal year 2023 are from the TANF fund for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding in each fiscal year must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding in each fiscal year must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 in fiscal year 2022 and $1,156,000 in fiscal year 2023 are from the TANF fund for family planning grants under Minnesota Statutes, section 145.925; and

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

under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

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

(c) **Maternal Morbidity and Death Studies.** $198,000 in fiscal year 2022 and $198,000 in fiscal year 2023 are from the general fund to be used to conduct maternal morbidity and death studies under Minnesota Statutes, sections 145.901 and 145.9013.

(d) **Comprehensive Advanced Life Support Educational Program.** $100,000 in fiscal year 2022 is from the general fund for the comprehensive advanced life support educational program under Minnesota Statutes, section 144.6062.

(e) **Local Public Health Grants.** $2,978,000 in fiscal year 2022 and $2,978,000 in fiscal year 2023 are from the general fund for local public health grants under Minnesota Statutes, section 145A.131. The base for this appropriation is $2,500,000 in fiscal year 2024 and $2,500,000 in fiscal year 2025.

(f) **Public Health Infrastructure and Health Equity and Outreach.** $5,000,000 in fiscal year 2022 and $5,000,000 in fiscal year 2023 are from the general fund for purposes of Minnesota Statutes, sections 144.067 to 144.069, and to build public health infrastructure at the state and local levels to address current and future public health emergencies, conduct outreach to underserved

communities in the state experiencing health disparities, and build systems at the state and local levels with the goals of reducing and eliminating health disparities in these communities.

(g) **Mental Health Cultural Community Continuing Education.** $500,000 in fiscal year 2022 and $500,000 in fiscal year 2023 are from the general fund for the mental health cultural community continuing education grant program.

(h) **Health Professional Education Loan Forgiveness Program.** $3,000,000 in fiscal year 2022 and $3,000,000 in fiscal year 2023 are from the general fund for loan forgiveness under the health professional education loan forgiveness program under Minnesota Statutes, section 144.1501, for individuals who: (1) are eligible alcohol and drug counselors or eligible mental health professionals, as defined in Minnesota Statutes, section 144.1501, subdivision 1; and (2) are Black, indigenous, or people of color, or members of an underrepresented community as defined in Minnesota Statutes, section 148E.010, subdivision 20. Loan forgiveness shall be provided according to this paragraph notwithstanding the priorities and distribution requirements for loan forgiveness in Minnesota Statutes, section 144.1501.

(i) **Birth Records; Homeless Youth.** $72,000 in fiscal year 2022 and $32,000 in fiscal year 2023 are from the general fund for administration and issuance of certified birth records and statements of no vital record found

to homeless youth under Minnesota Statutes, section 144.2255.

(j) **Skin Lightening Products Public Awareness and Education Grant Program.** $100,000 in fiscal year 2022 and $100,000 in fiscal year 2023 are from the general fund for a skin lightening products public awareness and education grant program. This is a onetime appropriation.

(k) **Trauma-Informed Gun Violence Reduction Pilot Program.** $100,000 in fiscal year 2022 is from the general fund for the trauma-informed gun violence reduction pilot program.

(l) **Home Visiting for Pregnant Women and Families with Young Children.** $2,500,000 in fiscal year 2022 and $2,500,000 in fiscal year 2023 are from the general fund for grants for home visiting services under Minnesota Statutes, section 145.87.

(m) **Supporting Healthy Development of Babies During Pregnancy and Postpartum.** $279,000 in fiscal year 2022 and $279,000 in fiscal year 2023 are from the general fund for a grant to the Amherst H. Wilder Foundation for the African American Babies Coalition initiative for community-driven training and education on best practices to support healthy development of babies during pregnancy and postpartum. Grant funds must be used to build capacity in, train, educate, or improve practices among individuals, from youth to elders, serving families with members who are Black, indigenous, or people of color, during pregnancy and postpartum. This is a

onetime appropriation. Any unexpended balance in the first year of the biennium does not cancel and is available in the second year of the biennium.

(n) **Dignity in Pregnancy and Childbirth.** $1,695,000 in fiscal year 2022 and $908,000 in fiscal year 2023 are from the general fund for purposes of Minnesota Statutes, section 144.1461. Of this appropriation, $845,000 in fiscal year 2022 is for a grant to the University of Minnesota School of Public Health's Center for Antiracism Research for Health Equity, to develop a model curriculum on anti-racism and implicit bias for use by hospitals with obstetric care and birth centers to provide continuing education to staff caring for pregnant or postpartum women. The model curriculum must be evidence-based and must meet the criteria in Minnesota Statutes, section 144.1461, subdivision 2, paragraph (a). The base for this appropriation is $907,000 in fiscal year 2024 and $860,000 in fiscal year 2025.

(o) **Recommendations to Expand Access to Data from the All-Payer Claims Database.** $55,000 in fiscal year 2022 is from the general fund for the commissioner to develop recommendations to expand access to data from the all-payer claims database under Minnesota Statutes, section 62U.04, to additional outside entities for public health or research purposes.

(p) **Base Level Adjustments.** The general fund base is $110,834,000 in fiscal year 2024 and $110,787,000 in fiscal year 2025. The state government special revenue fund base is

$7,777,000 in fiscal year 2024 and $7,777,000 in fiscal year 2025. The health care access fund base is $36,858,000 in fiscal year 2024 and $36,258,000 in fiscal year 2025.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	26,627,000	26,183,000
State Government Special Revenue	45,362,000	45,579,000

(a) **Lead Risk Assessments and Lead Orders.** $1,530,000 in fiscal year 2022 and $1,314,000 in fiscal year 2023 are from the general fund for implementation of the requirements for conducting lead risk assessments under Minnesota Statutes, section 144.9504, subdivision 2, and for issuance of lead orders under Minnesota Statutes, section 144.9504, subdivision 5.

(b) **Hospital Closure or Curtailment of Operations.** $10,000 in fiscal year 2022 and $1,000 in fiscal year 2023 are from the general fund for purposes of Minnesota Statutes, section 144.555, subdivisions 1a, 1b, and 2.

(c) **Transfer; Public Health Response Contingency Account.** The commissioner shall transfer $500,000 in fiscal year 2022 from the general fund to the public health response contingency account established in Minnesota Statutes, section 144.4199. This is a onetime transfer.

(d) **Base Level Adjustments.** The general fund base is $26,183,000 in fiscal year 2024 and $26,183,000 in fiscal year 2025. The state government special revenue fund base is

$45,579,000 in fiscal year 2024 and $45,579,000 in fiscal year 2025.

Subd. 4. **Health Operations** 11,570,000 11,579,000

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation** **$** **24,797,000** **$** **24,314,000**

Appropriations by Fund

State Government		
Special Revenue	24,721,000	24,238,000
Health Care Access	76,000	76,000

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

Subd. 2. **Board of Behavioral Health and Therapy** 700,000 698,000

Subd. 3. **Board of Chiropractic Examiners** 611,000 611,000

Subd. 4. **Board of Dentistry** 4,223,000 3,748,000

(a) **Administrative Services Unit - Operating Costs.** Of this appropriation, $2,738,000 in fiscal year 2022 and $2,263,000 in fiscal year 2023 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services it performs for other agencies.

(b) **Administrative Services Unit - Volunteer Health Care Provider Program.** Of this appropriation, $150,000 in fiscal year 2022 and $150,000 in fiscal year 2023 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative Services Unit - Retirement Costs.** Of this appropriation, $475,000 in fiscal year 2022 is a onetime appropriation to the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative services unit. These funds are available either year of the biennium.

(d) **Administrative Services Unit - Contested Cases and Other Legal Proceedings.** Of this appropriation, $200,000 in fiscal year 2022 and $200,000 in fiscal year 2023 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification by a health-related board to the administrative services unit that costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance for an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be

deposited in the state government special revenue fund.

Subd. 5. **Board of Dietetics and Nutrition Practice**	149,000	149,000
Subd. 6. **Board of Executives for Long Term Services and Supports**	368,000	310,000
Subd. 7. **Board of Marriage and Family Therapy**	395,000	393,000
Subd. 8. **Board of Medical Practice**	5,351,000	5,351,000

Health Professional Services Program. This appropriation includes $1,002,000 in fiscal year 2022 and $1,002,000 in fiscal year 2023 for the health professional services program.

Subd. 9. **Board of Nursing**	5,233,000	5,243,000
Subd. 10. **Board of Occupational Therapy Practice**	330,000	330,000
Subd. 11. **Board of Optometry**	191,000	191,000
Subd. 12. **Board of Pharmacy**	3,417,000	3,454,000

Appropriations by Fund

State Government Special Revenue	3,341,000	3,378,000
Health Care Access	76,000	76,000

Base Level Adjustment. The health care access fund base is $76,000 in fiscal year 2024, $38,000 in fiscal year 2025, and $0 in fiscal year 2026.

Subd. 13. **Board of Physical Therapy**	562,000	564,000
Subd. 14. **Board of Podiatric Medicine**	214,000	214,000
Subd. 15. **Board of Psychology**	1,275,000	1,273,000
Subd. 16. **Board of Social Work**	1,436,000	1,437,000
Subd. 17. **Board of Veterinary Medicine**	342,000	348,000

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD**	**$ 3,803,000**	**$ 3,829,000**

(a) **Cooper/Sams Volunteer Ambulance Program.** $950,000 in fiscal year 2022 and $950,000 in fiscal year 2023 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(1) Of this amount, $861,000 in fiscal year 2022 and $861,000 in fiscal year 2023 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(2) Of this amount, $89,000 in fiscal year 2022 and $89,000 in fiscal year 2023 are for the operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) **EMSRB Operations.** $1,880,000 in fiscal year 2022 and $1,880,000 in fiscal year 2023 are for board operations.

(c) **Regional Grants.** $585,000 in fiscal year 2022 and $585,000 in fiscal year 2023 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions under Minnesota Statutes, section 144E.52.

(d) **Ambulance Training Grant.** $361,000 in fiscal year 2022 and $361,000 in fiscal year 2023 are for training grants under Minnesota Statutes, section 144E.35.

Sec. 6. **COUNCIL ON DISABILITY** **$ 1,022,000 $ 1,038,000**

Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,487,000 $ 2,536,000**

Department of Psychiatry Monitoring. $100,000 in fiscal year 2022 and $100,000 in

fiscal year 2023 are for monitoring the Department of Psychiatry at the University of Minnesota.

Sec. 8. **OMBUDSPERSONS FOR FAMILIES** **$ 733,000 $ 744,000**

Sec. 9. Laws 2019, First Special Session chapter 9, article 14, section 3, as amended by Laws 2019, First Special Session chapter 12, section 6, is amended to read:

Sec. 3. **COMMISSIONER OF HEALTH**

~~**236,188,000**~~

Subdivision 1. **Total Appropriation** **$ 231,829,000 $ 233,584,000**

Appropriations by Fund

	2020	2021
		~~126,276,000~~
General	124,381,000	125,881,000
State Government		~~61,367,000~~
Special Revenue	58,450,000	59,158,000
Health Care Access	37,285,000	36,832,000
Federal TANF	11,713,000	11,713,000

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

Subd. 2. **Health Improvement**

Appropriations by Fund

		~~96,117,000~~
General	94,980,000	95,722,000
State Government		~~7,558,000~~
Special Revenue	7,614,000	6,924,000
Health Care Access	37,285,000	36,832,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 in fiscal year 2020 and $3,579,000 in fiscal year 2021 are from the TANF fund for home visiting and nutritional services under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards

according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2020 and $2,000,000 in fiscal year 2021 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2020 and $4,978,000 in fiscal year 2021 are from the TANF fund for the family home visiting grant program under Minnesota Statutes, section 145A.17. $4,000,000 of the funding in each fiscal year must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding in each fiscal year must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 in fiscal year 2020 and $1,156,000 in fiscal year 2021 are from the TANF fund for family planning grants under Minnesota Statutes, section 145.925; and

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

(b) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first

year of the biennium does not cancel but is available for the second year.

(c) **Comprehensive Suicide Prevention.** $2,730,000 in fiscal year 2020 and $2,730,000 in fiscal year 2021 are from the general fund for a comprehensive, community-based suicide prevention strategy. The funds are allocated as follows:

(1) $955,000 in fiscal year 2020 and $955,000 in fiscal year 2021 are for community-based suicide prevention grants authorized in Minnesota Statutes, section 145.56, subdivision 2. Specific emphasis must be placed on those communities with the greatest disparities. The base for this appropriation is $1,291,000 in fiscal year 2022 and $1,291,000 in fiscal year 2023;

(2) $683,000 in fiscal year 2020 and $683,000 in fiscal year 2021 are to support evidence-based training for educators and school staff and purchase suicide prevention curriculum for student use statewide, as authorized in Minnesota Statutes, section 145.56, subdivision 2. The base for this appropriation is $913,000 in fiscal year 2022 and $913,000 in fiscal year 2023;

(3) $137,000 in fiscal year 2020 and $137,000 in fiscal year 2021 are to implement the Zero Suicide framework with up to 20 behavioral and health care organizations each year to treat individuals at risk for suicide and support those individuals across systems of care upon discharge. The base for this appropriation is $205,000 in fiscal year 2022 and $205,000 in fiscal year 2023;

(4) $955,000 in fiscal year 2020 and $955,000 in fiscal year 2021 are to develop and fund a Minnesota-based network of National Suicide Prevention Lifeline, providing statewide coverage. The base for this appropriation is $1,321,000 in fiscal year 2022 and $1,321,000 in fiscal year 2023; and

(5) the commissioner may retain up to 18.23 percent of the appropriation under this paragraph to administer the comprehensive suicide prevention strategy.

(d) **Statewide Tobacco Cessation.** $1,598,000 in fiscal year 2020 and $2,748,000 in fiscal year 2021 are from the general fund for statewide tobacco cessation services under Minnesota Statutes, section 144.397. The base for this appropriation is $2,878,000 in fiscal year 2022 and $2,878,000 in fiscal year 2023.

(e) **Health Care Access Survey.** $225,000 in fiscal year 2020 and $225,000 in fiscal year 2021 are from the health care access fund to continue and improve the Minnesota Health Care Access Survey. These appropriations may be used in either year of the biennium.

(f) **Community Solutions for Healthy Child Development Grant Program.** $1,000,000 in fiscal year 2020 and $1,000,000 in fiscal year 2021 are for the community solutions for healthy child development grant program to promote health and racial equity for young children and their families under article 11, section 107. The commissioner may use up to 23.5 percent of the total appropriation for administration. The base for this appropriation

is $1,000,000 in fiscal year 2022, $1,000,000 in fiscal year 2023, and $0 in fiscal year 2024.

(g) **Domestic Violence and Sexual Assault Prevention Program.** $375,000 in fiscal year 2020 and $375,000 in fiscal year 2021 are from the general fund for the domestic violence and sexual assault prevention program under article 11, section 108. This is a onetime appropriation.

(h) **Skin Lightening Products Public Awareness Grant Program.** $100,000 in fiscal year 2020 and $100,000 in fiscal year 2021 are from the general fund for a skin lightening products public awareness and education grant program. This is a onetime appropriation.

(i) **Cannabinoid Products Workgroup.** $8,000 in fiscal year 2020 is from the state government special revenue fund for the cannabinoid products workgroup. This is a onetime appropriation.

(j) **Base Level Adjustments.** The general fund base is $96,742,000 in fiscal year 2022 and $96,742,000 in fiscal year 2023. The health care access fund base is $37,432,000 in fiscal year 2022 and $36,832,000 in fiscal year 2023.

Subd. 3. **Health Protection**

Appropriations by Fund		
General	18,803,000	19,774,000
State Government Special Revenue	50,836,000	~~53,809,000~~ 52,234,000

(a) **Public Health Laboratory Equipment.** $840,000 in fiscal year 2020 and $655,000 in fiscal year 2021 are from the general fund for

equipment for the public health laboratory. This is a onetime appropriation and is available until June 30, 2023.

(b) **Base Level Adjustment.** The general fund base is $19,119,000 in fiscal year 2022 and $19,119,000 in fiscal year 2023. The state government special revenue fund base is $53,782,000 in fiscal year 2022 and $53,782,000 in fiscal year 2023.

Subd. 4. **Health Operations**	10,598,000	10,385,000

Base Level Adjustment. The general fund base is $10,912,000 in fiscal year 2022 and $10,912,000 in fiscal year 2023.

EFFECTIVE DATE. This section is effective the day following final enactment and the reductions in subdivisions 1 to 3 are onetime reductions.

Sec. 10. **APPROPRIATION; MINNESOTA FAMILY INVESTMENT PROGRAM SUPPLEMENTAL PAYMENT.**

$24,235,000 in fiscal year 2021 is appropriated from the TANF fund to the commissioner of human services to provide a onetime cash benefit of up to $750 for each household enrolled in the Minnesota family investment program or diversionary work program under Minnesota Statutes, chapter 256J, at the time that the cash benefit is distributed. The commissioner shall distribute these funds through existing systems and in a manner that minimizes the burden to families. This is a onetime appropriation.

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

Sec. 11. **APPROPRIATION; REFINANCING OF EMERGENCY CHILD CARE GRANTS; CANCELLATION.**

$26,622,626 in fiscal year 2021 is appropriated from the coronavirus relief federal fund to the commissioner of human services for fiscal year 2020 to replace a portion of the general fund appropriation in Laws 2020, chapter 71, article 1, section 2, subdivision 9. The general fund appropriation that is replaced by coronavirus relief funds under this section is canceled to the general fund. This is a onetime appropriation.

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

Sec. 12. **CANCELLATION; TRANSFER FROM STATE GOVERNMENT SPECIAL REVENUE FUND TO GENERAL FUND.**

The $77,000 transfer each year from the state government special revenue fund to the general fund under Laws 2008, chapter 364, section 17, paragraph (b), is canceled. This section does not expire.

EFFECTIVE DATE. This section is effective June 30, 2021.

Sec. 13. **FEDERAL FUNDS FOR VACCINE ACTIVITIES; APPROPRIATION.**

Federal funds made available to the commissioner of health for vaccine activities are appropriated to the commissioner for that purpose and shall be used to support work under Minnesota Statutes, sections 144.067 to 144.069.

Sec. 14. **FEDERAL FUNDS REPLACEMENT; APPROPRIATION.**

Notwithstanding any law to the contrary, the commissioner of management and budget must determine whether the expenditures authorized under this act are eligible uses of federal funding received under the Coronavirus State Fiscal Recovery Fund or any other federal funds received by the state under the American Rescue Plan Act, Public Law 117-2. If the commissioner of management and budget determines an expenditure is eligible for funding under Public Law 117-2, the amount of the eligible expenditure is appropriated from the account where those amounts have been deposited and the corresponding general fund amounts appropriated under this act are canceled to the general fund.

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

Sec. 15. **TRANSFERS; HUMAN SERVICES.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2023, within fiscal years among the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid program, group residential housing program, the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health Finance and Policy Committee and Human Services Finance and Policy Committee quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health Finance and Policy Committee and Human Services Finance and Policy Committee quarterly about transfers made under this subdivision.

Sec. 16. **TRANSFERS; HEALTH.**

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

Sec. 17. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

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

Sec. 18. **APPROPRIATION ENACTED MORE THAN ONCE.**

If an appropriation in this act is enacted more than once in the 2021 legislative session, the appropriation must be given effect only once.

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

Sec. 19. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2023, unless a different expiration date is explicit.

Sec. 20. **REPEALER.**

Minnesota Statutes 2020, section 16A.724, subdivision 2, is repealed effective June 30, 2025.

Sec. 21. **EFFECTIVE DATE.**

This article is effective July 1, 2021, unless a different effective date is specified."