Bill Summary

H.F. 2128

As amended by H2128DE1

Subject	Health Omnibus Finance Bill
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Overview

This bill contains appropriation and policy provisions related to DHS health care programs, licensing and background studies, the Minnesota Department of Health, health boards, prescription drugs, health insurance, and telehealth.

Article 1: DHS Health Care Programs

This article contains provisions related to the medical assistance and MinnesotaCare programs.

Section	Description - Article 1: DHS Health Care Programs
1	**Applicability of chapter.** Adds § 62A.002. Provides that any benefit or coverage mandate in this chapter (regulation of health insurers) does not apply to managed care or county-based

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purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees.

2 **Applicability.**

Amends § 62C.01, by adding subd. 4. Provides that any benefit or coverage mandate in this chapter (regulation of nonprofit health service plan corporations) does not apply to managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees.

3 **Applicability.**

Amends § 62D.01, by adding subd. 3. Provides that any benefit or coverage mandate in this chapter (regulation of HMOs) does not apply to managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees.

4 **Applicability of chapter.**

Adds § 62J.011. Provides that any benefit or coverage mandate in this chapter (dealing with health care cost containment, health information technology, administrative simplification, patient protection, and other topics) does not apply to managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees.

5 **Applicability of chapter.**

Amends § 62Q.02. Provides that any benefit or coverage mandate in this chapter (health plan companies) does not apply to managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees.

6 **Other standards; wheelchair securement; protected transport.**

Amends § 174.30, subd. 3. Makes a conforming change in a cross-reference to MA nonemergency medical transportation coverage.

7 **Statewide health information exchange.**

Amends § 256.01, subd. 28. Gives the commissioner the authority to develop and operate, as part of a statewide health information exchange, an encounter alerting service.

8 **Hospital payment rates.**

Amends § 256.969, subd. 2b. Allows the commissioner, when rebasing inpatient hospital payment rates, to combine claims from two consecutive years if claims volume for a single year falls below the threshold needed for a statistically valid sample. Prohibits the use of years in which claims volume is reduced or altered due

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to a pandemic or public health emergency, if the base year includes more than one year.

9 **Alternate inpatient payment rate.**

Amends § 256.969, by adding subd. 2f. Requires the commissioner, effective July 1, 2021, to reduce the disproportionate share hospital (DSH) payment by … percent for a hospital with an MA utilization rate at least two and one-half standard deviations above the statewide mean, and compute an alternative inpatient payment rate for that hospital. The alternative payment rate must target total aggregate reimbursement equal to what the hospital would have received for fee-for-service inpatient services had the hospital received the full DSH payment. Specifies a January 1, 2022, effective date.

10 **Disproportionate numbers of low-income patients served.**

Amends § 256.969, subd. 9. Modifies the provisions governing disproportionate share hospital (DSH) payments, by: (1) basing the DSH adjustment for providing transplant services on all MA payments including managed care, not just fee-for-service payment; (2) clarifying an existing DSH payment for a hospital (HCMC) with an MA utilization rate at least 2.5 standard deviations above the statewide mean by adding the requirement that this hospital be a level one trauma center; and (3) specifying that the MA utilization rate and discharge thresholds used to determine eligibility for various DSH factors are to be measured using only one year, when a two-year base period is used.

Increases from $1.5 million to $9 million the amount of a payment adjustment for disproportionate share hospitals with high levels of administering high-cost drugs to MA fee-for-service enrollees (the adjustment takes into account as one factor 340B drug payments). Also allows a children's hospital that qualifies for an alternate inpatient payment rate to be eligible for this DSH payment. States that the section is effective January 1, 2023.

11 **Appeals.**

Amends § 256.9695, subd. 1. Extends from 12 to 18 months the time period, after the last day of the calendar year that is the base year, during which hospitals can appeal base year information used to set inpatient hospital payment rates.

12 **Fraud prevention investigations.**

Amends § 256.983. Includes tribal agencies as recipients of fraud prevention investigation grant funding, and requires tribal agencies to comply with the same requirements that apply to county grant recipients.

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13 **Administration of dental services.**

Adds § 256B.0371. (a) Effective January 1, 2023, requires the commissioner to contract with a dental administrator to administer dental services for MA and MinnesotaCare enrollees, including those persons enrolled in managed care as described in § 256B.69.

(b) Requires the administrator to provide administrative services, including but not limited to: provider recruitment, contracting, and assistance; recipient outreach and assistance; utilization management and reviews of medical necessity; claims processing; service coordination; management of fraud and abuse; monitoring access to services; performance measurement; quality improvement and evaluation; and management of third-party liability requirements.

(c) Sets payment rates at the MA rate as established under section 256B.76.

Provides a January 1, 2023, effective date.

14 **Limitation on services.**

Amends § 256B.04, subd. 12. Strikes outdated language related to service delivery and reimbursement for emergency and nonemergency transportation providers, and other providers.

15 **Competitive bidding.**

Amends § 256B.04, subd. 14. Allows the commissioner to volume purchase through competitive bidding and negotiation allergen-reducing products as described in section 256B.0625, subd. 67, paragraph (c) or (d).

Allows the commissioner to use volume purchase through competitive bidding for nonemergency medical transportation generally (current law limits this to level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursement). Also eliminates the specific prohibition on the use of volume purchase through competitive bidding for special transportation services.

16 **Pregnant women; needy unborn child.**

Amends § 256B.055, subd. 6. Extends MA coverage for pregnant women from 60 to 180 days postpartum. States that the section is effective January 1, 2022, or upon federal approval, whichever is later.

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17 **Eligibility verification.**

Amends § 256B.056, subd. 10. Makes a conforming change related to the extension of MA coverage for pregnant women to 180 days postpartum. States that the section is effective January 1, 2022, or upon federal approval, whichever is later.

18 **Qualified Medicare beneficiaries.**

Amends § 256B.057, subd. 3. Sets the asset limit for eligibility for Medicare savings programs (programs that assist low-income Medicare beneficiaries with Medicare premiums and cost-sharing) at the current level -- $10,000 for one and $18,000 for two or more individuals, or at the asset level for the Medicare Part D extra help low income subsidy (LIS), once this indexed asset level exceeds the current asset limits. States that this section is effective the day following final enactment.

19 **Citizenship requirements.**

Amends § 256B.06, subd. 4. Makes a conforming change related to the extension of MA coverage for pregnant women to 180 days postpartum. States that the section is effective January 1, 2022, or upon federal approval, whichever is later.

20 **Health Services Advisory Council.**

Amends § 256B.0625, subd. 3c. Makes a number of changes related to the Health Services Advisory Council. These include:

- renaming the Health Services Policy Committee the Health Services Advisory Council;
- requiring the council to advise the commissioner on evidence-based decision-making and health care benefit and coverage policies for Minnesota health care programs;
- eliminating language that requires the chair to be a physician;
- allowing the council to monitor and track practice patterns of health care providers generally (current law allows this for physicians); and
- striking obsolete language and making conforming and related changes.

21 **Health Services Advisory Council members.**

Amends § 256B.0625, subd. 3d. Modifies council membership by:

- reducing the number of physicians from seven to six, and striking the requirement that one physician be actively engaged in treating persons with mental illness;
- adding one member who is a health care or mental health professional actively engaged in treating persons with mental illness; and
- increasing the number of consumer members from one to two.

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Also clarifies what constitutes a quorum and renames the committee.

22 **Health Services Advisory Council.**

Amends § 256B.0625, subd. 3e. Renames the Health Services Advisory Committee the Health Services Advisory Council and makes conforming changes.

23 **Dental services.**

Amends § 256B.0625, subd. 9. Requires the commissioner to contract with a dental administrator for the administration of dental services, including the administration of dental services for persons enrolled in managed care as described in § 256B.69. Makes conforming changes.

Expands MA coverage of dental services for nonpregnant adults, to include coverage of nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures. This expansion of coverage also applies to the MinnesotaCare program, through cross-reference elsewhere in statute.

Provides a January 1, 2023, effective date.

24 **Drugs.**

Amends § 256B.0625, subd. 13. Allows a 90-day supply of a prescription drug to be dispensed under MA, if the drug appears on the 90-day supply list published by the commissioner. Requires the list to be published on the DHS website. Allows the commissioner to modify the list after providing public notice and a 15-day comment period. Provides that the list may include cost-effective generic drugs, but shall not include controlled substances.

Requires each 340B covered entity and ambulatory pharmacy under common ownership of the covered entity to report to the commissioner, by March 1 of each year, reimbursement for the previous calendar year from each managed care and county-based purchasing plan, or from the PBM under contract with the plan. Requires the aggregate cost of drugs purchased through the 340B program, and other specified information, to be reported. Directs the commissioner to submit a copy of the reports to the legislature, by April 1 of each year. States that 340B drugs acquired and dispensed by a 340B covered entity or ambulatory pharmacy under common ownership are not eligible for coverage if the covered entity fails to submit the required report.

25 **Formulary Committee.**

Amends § 256B.0625, subd. 13c. Removes the June 30, 2022, expiration date for the Formulary Committee, and provides that the committee does not expire.

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26 **Drug formulary.**

Amends § 256B.0625, subd. 13d. Allows MA to cover drugs or active pharmaceutical ingredients used for weight loss. Under current law, the MA formulary only covers drugs for weight loss if they are medically necessary lipase inhibitors used by recipients with Type II diabetes.

27 **Transportation costs.**

Amends § 256B.0625, subd. 17. Makes various changes to MA coverage of NEMT services, including changes related to the use of an administrator. These changes include:

- striking references to the Nonemergency Medical Transportation Advisory Committee (this committee is repealed elsewhere in the article);
- striking references to the single administrative structure;
- replacing a reference to "local agency" with a reference to the "administrator" and striking a provision designating the local agency as the single administrative agency; and
- striking the existing language on NEMT reimbursement for the various modes of service.

28 **Documentation required.**

Amends § 256B.0625, subd. 17b. Allows funds paid for NEMT transportation that is not documented to be recovered by the NEMT vendor, as well as the department.

29 **Public transit or taxicab transportation.**

Amends § 256B.0625, subd. 18. Allows the commissioner to provide a monthly public transit pass for the nonemergency medical transportation needs of MA recipients who are well-served by public transit. Provides that recipients are eligible for a transit pass if they are eligible for one public transit trip for a covered service during a month. These recipients are then not eligible for other modes of transportation, unless an unexpected need arises that cannot be accessed through public transit. Prohibits the commissioner from requiring recipients to select a transit pass, if their transportation needs cannot be served by public transit. States that this section is effective January 1, 2022.

30 **Administration of nonemergency medical transportation.**

Amends § 256B.0625, subd. 18b. Requires the commissioner to contract, either statewide or regionally, for the administration of the NEMT program. Specifies that the contract must also include administration of all covered modes of NEMT services for those enrolled in managed care under § 256B.69. Also strikes language that

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limited the use of a broker or coordinator for NEMT services to establishing the level of service.

31 **Other clinic services.**

Amends § 2567B.0625, subd. 30. For purposes of rebasing encounter rates for federally qualified health centers (FQHCs) and rural health clinics, prohibits the use of years in which costs or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency, when the base year includes more than one year. Allows the commissioner to use Medicare cost reports of a year unaffected by pandemic, disease, or other public health emergency, or the previous two consecutive years, inflated to the base year.

32 **Medical supplies and equipment.**

Amends § 256B.0625, subd. 31. States that allergen-reducing products provided according to subd. 67, paragraph (c) or (d), shall be considered durable medical equipment. States that the section is effective January 1, 2022, or upon federal approval, whichever is later.

33 **Early and periodic screening, diagnosis, and treatment services.**

Amends § 256B.0625, subd. 58. (a) Requires the commissioner, in administering the EPSDT program, to, at a minimum:

1) provide information to children and families on the benefits of preventative visits, services available, and assistance in finding a provider, transportation, or interpreter services;
2) maintain an up-to-date periodicity schedule in the department policy manual; and
3) maintain up-to-date policies for providers on delivering EPSDT services that are in the provider manual on the department website.

(b) Allows the commissioner to contract for the administration of outreach services as required by the EPSDT program.

(c) Allows the commissioner to contract for required EPSDT outreach services, including but not limited to children enrolled in or attributed to an integrated health partnership (IHP) demonstration project. Requires IHPs that choose to provide EPSDT outreach services to receive compensation from the commissioner on a per-member, per-month basis for each child. Specifies related requirements. Provides that this paragraph is effective January 1, 2022.

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34 **Enhanced asthma care services.**

Amends § 256B.0625, by adding subd. 67. (a) States that MA covers enhanced asthma care services and related products provided in children's homes for children with poorly controlled asthma. To be eligible, requires a child:

1) to be under age 21;
2) to have poorly controlled asthma, defined as having received asthma care from a hospital emergency department at least once in the past year or having been hospitalized for the treatment of asthma at least once in the past year; and
3) to have received a referral for services and products under this subdivision from a treating health care provider.

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

(c) Requires covered products to be identified 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 professional providing asthma care, and proven to reduce asthma triggers. Lists specific products covered.

(d) Requires the commissioner to determine other products that may be covered, as new best practices for asthma are identified.

(e) Defines a home assessment as a home visit to identify asthma triggers and to provide education on trigger-reducing products. Limits a child to two home assessments, except that an additional home assessment may be provided if the child moves to a new home, a new asthma trigger enters the home, or if the child's health care provider identifies a new allergy for the child. Requires the commissioner to determine the frequency with which a child may receive a product listed in paragraph (c) or (d), based on the reasonable expected lifetime of the product.

States that the section is effective January 1, 2022, or upon federal approval, whichever is later.

35 **Cost-sharing.**

Amends § 256B.0631, subd. 1. Exempts medications when used to prevent or treat HIV from MA copayments. States that the section is effective January 1, 2022, subject to federal approval.

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36 **Opioid prescribing work group.**

Amends § 256B.0638, subd. 3. Adds to the opioid prescribing work group two consumer members who are Minnesota residents and who have used or are using opioids to manage chronic pain. Also adds a representative of the Minnesota Department of Health as a nonvoting member.

37 **Program implementation.**

Amends § 256B.0638, subd. 5. Modifies the procedure used to report opioid prescriber data, by requiring the commissioner to report to provider groups data on individual prescribers' prescribing patterns, and requiring provider groups to distribute this data to prescribers. Under current law, the commissioner reports to prescribers.

38 **Data practices.**

Amends § 256B.0638, subd. 6. Allows the commissioner to share with provider groups data on prescribers' prescribing patterns. Under current law, the information shared is limited to information on prescribers who are subject to quality improvement activities.

39 **Qualified professional; qualifications.**

Amends § 256B.0659, subd. 13. Eliminates a requirement that DHS enroll qualified professionals who work for personal care assistance provider agencies. Requires qualified professionals to meet provider training requirements and strikes outdated language.

40 **Commissioner's duties.**

Amends § 256B.196, subd. 2. Removes Hennepin County from an existing voluntary intergovernmental transfer, under which Hennepin County would transfer to the commissioner $12 million per year. Provides that this section is effective January 1, 2022, or upon federal approval of this section and § 256B.1973, whichever is later.

41 **Directed payment arrangements.**

Adds § 256B.1973.

Subd. 1. Definitions. Defines the following terms: billing professionals, health plan, and high medical assistance utilization.

Subd. 2. Federal approval required. States that 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.

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Subd. 3. Eligible providers. States that eligible providers under this section are nonstate government teaching hospitals with high MA utilization and a level I trauma center, and the hospital's affiliated billing professionals, ambulance services, and clinics.

Subd. 4. Voluntary intergovernmental transfers. Allows a nonstate governmental entity eligible to perform intergovernmental transfers to make voluntary intergovernmental transfers to the commissioner. Requires the commissioner to inform the entity of the transfers necessary to maximize the allowable directed payments.

Subd. 5. Commissioner's duties; state-directed fee schedule requirement. (a) Requires the commissioner, for each federally approved directed payment arrangement that is a state-directed fee schedule requirement, to determine a uniform adjustment factor for each claim submitted to a health plan and to apply this to each claim. Directs the commissioner to ensure that the adjustment factor maximizes the allowable directed payments and does not result in payments exceeding federal limits, and allows the commissioner to use a settle-up process to adjust health plan payments to comply with this requirement.

(b) Requires the commissioner to develop a plan for initial implementation of the state-directed fee schedule requirement to ensure that eligible providers receive the entire permissible value under each arrangement. If federal approval is retroactive, requires the commissioner to make a onetime pro rata increase in the adjustment factor and initial payments.

Subd. 6. Health plan duties; submission of claims. Requires each health plan to submit to the commissioner payment information for each claim paid to an eligible provider for MA services.

Subd. 7. Health plan duties; directed payments. Requires each health plan to 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. Requires the directed payment arrangement and the state-directed fee schedule requirement to align with state quality goals for Hennepin Healthcare MA patients. Specifies related requirements and quality measure domains.

States that this section is effective January 1, 2022, or upon federal approval, whichever is later, and allows for retroactive implementation.

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42 **Prescription drugs.**

Amends § 256B.69, subd. 6d. Requires the commissioner to exclude (carve out) outpatient drugs from MA managed care contracts. States that the section is effective January 1, 2023.

43 **Annual report on provider reimbursement rates.**

Amends § 256B.69, by adding subd. 9f. (a) Requires the commissioner, by December 15 of each year, to report to the legislature on managed care and county-based purchasing plan provider reimbursement rates. Requires compliance with general requirements for reports to the legislature (e.g. transmittal to Legislative Reference Library, statement of cost).

(b) Requires the report to include, for each managed care and county-based purchasing plan, the mean provider reimbursement rates by county for the preceding calendar year, for the five most common billing codes statewide across all plans, for the following 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) Requires the commissioner to also include in the report: (1) the mean and median reimbursement rates by county for the preceding calendar year for the billing codes and service categories described in paragraph (b); and (2) the mean and median fee-for-service reimbursement rates by county for the preceding calendar year for the billing codes and service categories described in paragraph (b).

44 **Annual report on prepaid health plan reimbursement to 340B covered entities.**

Amends § 256B.69, by adding subd. 9g. (a) Requires managed care and county-based purchasing plans, by March 1 of each year, to report to the commissioner their reimbursement to 340B covered entities for the previous calendar year. Specifies the information that must be reported.

(b) Requires the commissioner to submit a copy of the reports to the legislature by April 1 of each year.

45 **Direction of managed care organization expenditures.**

Amends § 256B.6928, subd. 5. Allows the commissioner to direct managed care organization expenditures as permitted under the federal rule governing Medicaid directed payments (42 CFR 438.6(c)).

46 **Hospital outpatient reimbursement.**

Amends § 256B.75. Effective for services provided on or after July 1, 2021, requires payments to critical access hospitals for outpatient, emergency, and ambulatory surgery facility fee services to be increased for hospitals providing high levels of high-

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cost or 340B drugs. Requires the adjustment to be based on each hospital's share of total reimbursement for 340B drugs to all critical access hospitals, but not to exceed a certain percentage.

Directs the commissioner, when implementing prospective payment methodologies for outpatient hospital services, to use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for outpatient hospital and ambulatory surgical center settings, unless other payment methodologies are specified in state MA law.

47 **Dental reimbursement.**

Amends § 256B.76, subd. 2. Sunsets existing MA dental payment rates effective January 1, 2023.

A new paragraph (l) sets payments for dental services provided on or after January 1, 2023, at the lower of the submitted charge or the first percentile of 2018 submitted charges. States that this paragraph does not apply to FQHCs, rural health centers, state-operated dental clinics, or Indian health centers.

A new paragraph (m) requires dental payment rates to be rebased beginning January 1, 2026, and every four years thereafter, to the first percentile of submitted charges for the applicable base year (the calendar year two years prior to the effective date of rebasing).

48 **Dental home pilot program.**

Amends § 256B.76, by adding subd. 2a. Requires the commissioner, in consultation with dental stakeholders, to design a dental home pilot program for implementation beginning January 1, 2023. Requires the program to provide incentives for the provision of high-quality, patient-centered, comprehensive, and coordinated oral health services.

49 **Critical access dental providers.**

Amends § 256B.76, subd. 4. Provides that MA critical access dental payments are in effect only through December 31, 2022 (these payments are ongoing under current law).

50 **Reimbursement for basic care services.**

Amends § 256B.766. Makes various changes to reimbursement methods for durable medical equipment, medical supplies, prosthetics, and orthotics.

The amendment to paragraph (i) terminates, after June 30, 2021, individual pricing for certain medical supplies and durable medical equipment and a prohibition on any

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MA rate reductions to durable medical equipment as a result of Medicare competitive bidding.

The amendment to paragraph (j) terminates, after June 30, 2021, various rate increases for durable medical equipment, prosthetics, orthotics, or supplies.

The amendment to paragraph (k) terminates, after June 30, 2021, certain payment rate provisions for ventilators.

A new paragraph (m) provides that effective July 1, 2021, payment rates for all durable medical equipment, prosthetics, orthotics, or supplies, except pressure support ventilators, shall be at the lesser of submitted charges or the Medicare fee schedule amount, without any increases or decreases in paragraphs (a) to (k) applied. Requires pressure support ventilators to be paid at the Medicare rate plus 47 percent.

A new paragraph (n) sets payment rates, effective July 1, 2021, for items for which Medicare has not established a payment amount at the lesser of submitted charges or an alternate payment methodology rate, without any increases or decreases in paragraphs (a) to (k) applied. Specifies criteria for the alternate payment methodology rate.

A new paragraph (o) sets the payment at the provider's actual acquisition cost plus 20 percent, until sufficient data is available to calculate the alternate payment methodology.

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

51 **Medicare payment limit.**

Amends § 256B.767. Strikes the exemption of durable medical equipment, prosthetics, orthotics, and supplies from a general provision providing that the MA payment rate not exceed the Medicare payment rate.

52 **Definitions.**

Amends § 256B.79, subd. 1. Modifies the definition of "targeted populations" for the integrated care for high-risk pregnant women grant program, to refer to pregnant MA enrollees residing in "communities" rather than "geographic areas."

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53	**Grant awards.** Amends § 256B.79, subd. 3. Strikes language that requires integrated perinatal care collaboratives that received grants prior to January 1, 2019, to be given priority when determining subsequent grants.
54	**Income.** Amends § 256L.01, subd. 5. Defines "income" under MinnesotaCare as projected annual income for the applicable tax year, and strikes references to current income and income during the 12-month eligibility period. Provides that the section is effective the day following final enactment. (The changes in this section and the sections related to income limit adjustments and eligibility redetermination that follow reflect the failure of the Centers for Medicare and Medicaid Services to approve Minnesota eligibility determination changes passed in 2016 and reflected in current law.)
55	**Cost-sharing.** Amends § 256L.03, subd. 5. Exempts from MinnesotaCare co-payments pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of HIV. States that the section is effective January 1, 2022, subject to federal approval.
56	**Annual income limits adjustment.** Amends § 256L.04, subd. 7b. Requires the commissioner to adjust MinnesotaCare income limits annually on January 1, rather than each July 1. Provides that the section is effective the day following final enactment.
57	**Redetermination of eligibility.** Amends § 256L.05, subd. 3a. Specifies that the period of MinnesotaCare eligibility is the calendar year, and that eligibility redeterminations shall occur during the open enrollment period for qualified health plans. Strikes language that defined the period of eligibility as the 12-month period beginning the month of application, with renewals being implemented throughout the year. Provides that the section is effective the day following final enactment.
58	**Dental providers.** Amends § 256L.11, subd. 6a. Provides that the MinnesotaCare dental payment rate increase of 54 percent is in effect only through December 31, 2022 (these payments are ongoing under current law).

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59 **Critical access dental providers.**

Amends § 256L.11, subd. 7. Provides that MinnesotaCare critical access dental payments are in effect only through December 31, 2022 (these payments are ongoing under current law).

60 **Exclusions and exemptions.**

Amends § 295.53, subd. 1. Excludes from the MinnesotaCare provider tax directed payments authorized under § 256B.1973. States that this section is effective for taxable years beginning after December 31, 2021.

61 **Court ruling on Affordable Care Act.**

In the event the U.S. Supreme Court reverses the Affordable Care Act (ACA), requires the commissioner of human services to take all actions necessary to maintain current MA and MinnesotaCare policies, including pursuing federal funds or, if federal funds are not available, using state funds for at least a year following the Supreme Court decision or until the conclusion of the next regular legislative session, whichever is later.

62 **Delivery reform analysis report.**

Requires the commissioner of human services to present to the legislature, by January 15, 2023, a report comparing service delivery and payment models for MinnesotaCare and certain MA enrollees. Specifies report requirements.

63 **Direction to commissioner; income and asset exclusion for St. Paul guaranteed income demonstration project.**

Subd. 1. Definitions. Defines the terms “commissioner” and “guaranteed income demonstration project.”

Subd. 2. Commissioner; income and asset exclusion. Paragraph (a) prohibits the commissioner from counting payments made to families by the guaranteed income demonstration project as income or assets for purposes of determining or redetermining eligibility for child care assistance programs and MFIP, the work benefit program, or DWP.

Paragraph (b) prohibits the commissioner from counting payments made to families by the guaranteed income demonstration project as income for purposes of determining or redetermining eligibility for MA or MinnesotaCare.

Subd. 3. Report. Requires the city of St. Paul to provide a report to 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.

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Subd. 4. Expiration. Makes this section expire June 30, 2023.

Provides a July 1, 2021, effective date, except for subdivision 2, paragraph (b), which is effective July 1, 2021, or upon federal approval, whichever is later.

64 **Expansion of outpatient drug carve out; prescription drug purchasing program.**

Requires the commissioner of human services, in consultation with the commissioners of commerce and health, to assess and develop recommendations related to: (1) expanding the managed care drug carve out to include MinnesotaCare; and (2) establishing a prescription drug purchasing program to serve persons with private sector insurance coverage. Specifies criteria for the recommendations and requires a report to the legislature by December 15, 2023.

65 **Federal approval; extension of postpartum coverage.**

Requires the commissioner of human services to seek all federal waivers and approvals necessary to extend MA coverage for pregnant women to 180 days postpartum. States that the section is effective the day following final enactment.

66 **Proposal for a public option.**

Requires the commissioner of human services, in consultation with other entities, to develop a proposal for a public option program. Specifies requirements for the public option and public option proposals. Requires the commissioner to report to the legislature by December 15, 2021.

67 **Response to COVID-19 public health emergency.**

(a) Prohibits the commissioner from collecting any unpaid premium under MA employer persons with disabilities or MinnesotaCare, for a coverage month that occurred during the federal COVID-19 public health emergency.

(b) Allows the commissioner to suspend periodic data matching for up to six months following the last day of the federal COVID-19 public health emergency.

(c) Suspends the requirement that the commissioner issue an annual report on periodic data matching, for one year following the last day of the federal COVID-19 public health emergency.

Provides that this section is effective the day following final enactment, except that paragraph (a) as it relates to MinnesotaCare premiums is effective upon federal approval.

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68	**Revisor instruction.** Directs the revisor to change the term "Health Services Policy Committee" to "Health Services Advisory Council" wherever it appears in law, and make conforming changes.
69	**Repealer.** (a) Repeals rules related to the EPSDT program, effective July 1, 2021. (b) Repeals § 256B.0625, subd. 18c (nonemergency medical transportation advisory committee), 18d (advisory committee members), 18e (single administrative structure and delivery system for NEMT), and 18h (NEMT provisions applicable to managed care and county-based purchasing plans). Provides a January 1, 2023, effective date.

Article 2: DHS Licensing and Background Studies

This article includes modifications to human services licensing statutes related to withdrawal management, detoxification programs, and family foster settings. It also establishes new standards for family foster setting licensure applicant background studies, adds professions and individuals to undergo DHS background studies, establishes alternative background studies standards, and moves DHS background studies to a fee schedule.

Section	Description - Article 2: DHS Licensing and Background Studies
1	**Background study required.** Amends § 62V.05 by adding subd. 4a. Requires the Board of Directors of MNsure to initiate human services background studies of navigators, in-person assisters, and certified application counselors; prohibits any individual from providing services until the board receives notice that the individual is not disqualified, or if a disqualification was set aside. Requires the board or a delegate to review reconsideration requests.
2	**Background studies.** Amends § 122A.18, subd. 8. Modifies terminology for the Professional Educator Licensing and Standards Board (PELSB) and the Board of School Administrators background studies.
3	**Denial of application.** Amends § 245A.05. Specifies that the commissioner of human services may deny an applicant for a family foster setting license if the applicant has non-disqualifying background study information that reflects on the applicant's ability to safely care for foster children.

Section	Description - Article 2: DHS Licensing and Background Studies

Makes this section effective July 1, 2022.

4 **Sanctions; appeals; license.**

Amends § 245A.07, subd. 1. Allows the commissioner of human services to take adverse licensing action if a license holder has non-disqualifying background study information that reflects on the applicant's ability to safely care for foster children.

Makes this section effective July 1, 2022.

5 **License or certification fee for certain programs.**

Amends § 245A.10, subd. 4. Modifies terminology to clarify detoxification and withdrawal management program licensure fees.

6 **Licensed family foster settings.**

Amends § 245A.16 by adding subd. 9. Requires a county agency or private agency to review specified information relating to non-disqualifying background study results before recommending to grant, deny, or revoke a family foster setting license. Lists information that must be reviewed; lists what constitutes "evidence of rehabilitation."

Requires the commissioner to consider relative relationships as a significant factor in determining a licensing decision; requires the county or private licensing agency to send a summary of the completed review to the commissioner and to include a recommendation for licensing action.

Makes this section effective July 1, 2022.

7 **Authorized fingerprint collection vendor.**

Amends § 245C.02, subd. 4a. Allows the commissioner to retain more than one authorized fingerprint collection vendor.

8 **Background study.**

Amends § 245C.02, subd. 5. Adds collection and processing of fingerprints and photograph to definition of background study.

9 **Alternative background study.**

Amends § 245C.02 by adding subd. 5b. Adds definition of "alternative background study" to the human services background studies chapter.

10 **Entity.**

Amends § 245C.02 by adding subd. 11c. Adds definition of "entity" to the human services background studies chapter.

Section	Description - Article 2: DHS Licensing and Background Studies

11 **Results.**

Amends § 245C.02 by adding subd. 16a. Adds definition of "results" to the human services background studies chapter.

12 **Background study; individuals to be studied.**

Amends § 245C.03. Adds and modifies the subdivisions below.

Subd. 1. Licensed programs. Adds list of licensed programs to which the subdivision applies.

Subd. 1a. Procedure. Clarifies procedural requirements for background studies.

Subd. 3a. Personal care assistance provider agency; background studies. Establishes background study requirements for personal care assistance provider agencies enrolled to provide personal care assistance services under medical assistance; requires some owners, all managing employees, and all qualified professionals to undergo a background study.

Subd. 3b. Exception to personal care assistant; requirements. Allows a personal care assistant for a recipient to enroll with a different provider agency upon initiation of a new background study, under specified circumstances.

Subd. 5a. Facilities serving children or adults licensed or regulated by the Department of Health. Requires the commissioner of health to contract with DHS to conduct background studies for individuals providing direct contact services in a range of entities licensed by the Department of Health, and other employees in certain types of licensed entities facilities. Specifies that if a program is jointly licensed, DHS is solely responsible for the background studies.

Subd. 5b. Facilities serving children or youth licensed by the Department of Corrections. Requires DHS to conduct background studies of individuals providing direct contact services in residential and detention facilities, and requires specified individuals and entities to provide DHS with all available criminal conviction data related to individuals to be studied under this subdivision. Requires DHS to notify an individual and the facility of a disqualification, and of the right to request reconsideration through the Department of Corrections. Specifies reconsideration procedures.

Subd. 6. Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities. Specifies that individuals who provide direct contact services specified in federally approved home and community-based waiver plans under section 256B.4712 consumer-directed community supports, upon federal approval, must meet background study requirements.

Section	Description - Article 2: DHS Licensing and Background Studies

Subd. 6a. Legal nonlicensed and certified child care programs. Makes clarifying changes; specifies that DHS background studies are required for each individual who applies for child care program certification, each member of a provider's household age 13 or older, and a member of a provider's household who is aged 10 to 13, if reasonable cause exists.

Subd. 7. Children's therapeutic services and supports providers. Clarifies that all direct service providers and volunteers for children's therapeutic services and supports providers are subject to background studies.

Subd. 9. Community first services and supports organizations. Establishes background study requirements for individuals affiliated with Community First Services and Supports (CFSS) agency-providers and Financial Management Services (FMS) providers enrolled to provide CFSS services under medical assistance.

Subd. 9a. Exception to support worker requirements for continuity of services. Allows a support worker for a participant to enroll with a different CFSS agency-provider or FMS provider upon initiation, rather than completion, of a new background study under specified circumstances.

Subd. 10. Providers of group residential housing or supplementary services. Clarifies who must undergo a background study related to providers of group residential housing or supplementary services; requires compliance with all background study requirements.

Subd. 11. Strikes subdivision relating to child protection workers.

Subd. 12. Providers of special transportation service. Clarifies which individuals providing special transportation services must undergo a background study. Allows a local or contracted agency authorizing a nonemergency medical transportation service ride by a volunteer driver to initiate a background study under certain circumstances.

Subd. 13. Providers of housing support services. Makes clarifying changes.

Subd. 14. Tribal nursing facilities. Requires the commissioner to obtain state and national criminal history data for individuals affiliated with a tribally licensed nursing facility.

Subd. 15. Early intensive developmental and behavioral intervention providers. Requires the commissioner to conduct a background study when initiated by an early intensive developmental and behavioral intervention provider.

Section	Description - Article 2: DHS Licensing and Background Studies

13 **Background study; alternative background studies.**

Proposes coding for § 245C.031.

Subd. 1. Alternative background studies. Requires the commissioner to conduct an alternative background study of individuals listed in this section; establishes required procedures for studies and data destruction.

Subd. 2. Access to information. Requires each entity that submits an alternative background study to enter into an agreement with the commissioner to comply with state and federal law.

Subd. 3. Child protection workers or social services staff having responsibility for child protective duties. Requires an alternative background study for these individuals.

Subd. 4. Applicants, licensees, and other occupations regulated by the commissioner of health. Requires alternative background studies for applicants for audiologist or speech-language pathologist licenses or renewals or applicants for hearing instrument dispenser initial certification or certification before January 1, 2018. Establishes alternative background study requirements for these individuals.

Subd. 5. Guardians and conservators. Requires alternative background studies for court-appointed guardians and conservators, with certain exceptions, to be completed prior to the appointment of the guardian or conservator, unless the best interests of the ward or protected person requires appointment before the study is completed.

Subd. 6. Guardians and conservators; required checks. Specifies data to be checked for guardian and conservator alternative background studies.

Subd. 7. Guardians and conservators; state licensing data. Requires the commissioner to provide the court with licensing agency data, within 25 working days, for licenses directly related to the responsibilities of a professional fiduciary, if the study subject is or has been affiliated with a listed professional licensing entity. Requires an agreement by each entity to provide the commissioner with electronic access to relevant licensing data and quarterly lists of new sanctions. Establishes additional procedures for providing licensing data to the court for guardian and conservator background studies.

Subd. 8. Guardians ad litem. Requires alternative background studies for guardians ad litem once every three years.

Section	Description - Article 2: DHS Licensing and Background Studies

Subd. 9. Guardians ad litem; required checks. Specifies data to be checked and required procedures for alternative background studies for guardians ad litem.

Subd. 10. First-time applicants for educator licenses with the Professional Educator Licensing and Standards Board. Requires PELSB to make eligibility determinations for alternative background studies. Permits alternative background studies for all first-time applicants for educator licenses; specifies what the studies must include.

Subd. 11. First-time applicants for administrator licenses with the Board of School Administrators. Requires the Board of School Administrators to make eligibility determinations for alternative background studies. Permits alternative background studies for all first-time applicants for administrator licenses; specifies what the studies must include.

Subd. 12. Occupations regulated by MNsure. Requires the commissioner to conduct a background study of any individual required to have a background study under section 62V.05.

14 **Individual studied.**

Amends § 245C.05, subd. 1. Clarifies language; requires a background study subject to submit a completed criminal and maltreatment history records check consent form for applicable record checks.

15 **Applicant, license holder, or other entity.**

Amends § 245C.05, subd. 2. Makes clarifying change.

16 **County or private agency.**

Amends § 245C.05, subd. 2a. Makes clarifying change.

17 **County agency to collect and forward information to commissioner.**

Amends § 245C.05, subd. 2b. Makes clarifying changes.

18 **Privacy notice to background study subject.**

Amends § 245C.05, subd. 2c. Removes provision stating that the FBI will only keep fingerprints from national criminal history background checks if the subject has a criminal history; states that the FBI will not retain fingerprints; makes clarifying change related to fingerprint vendors.

Section	Description - Article 2: DHS Licensing and Background Studies
19	**Fingerprint data notification.** Amends § 245C.05, subd. 2d. Removes provision stating that the FBI will only keep fingerprints from national criminal history background checks if the subject has a criminal history; states that the FBI will not retain fingerprints.
20	**Electronic transmission.** Amends § 245C.05, subd. 4. Adds a summary of nondisqualifying background study results and relevant underlying investigative information to the information that DHS must transmit electronically to county and private agencies for child foster care; makes clarifying changes. Makes this section effective July 1, 2022.
21	**Arrest and investigative information.** Amends § 245C.08, subd. 3. Removes language prohibiting the sharing of national criminal history check information with county and private agencies. Makes this section effective July 1, 2021.
22	**Authorization.** Amends § 245C.08 by adding subd. 5. Specifies that the commissioner is authorized to receive background study information.
23	**Background study fees.** Amends § 245C.10 by adding subd. 1b. Specifies that the commissioner shall recover background study costs, and that fees collected are appropriated to the commissioner for the purpose of conducting background studies. Lists what background study fees may include and how they may be paid.
24	**Fingerprint and photograph processing fees.** Amends § 245C.10 by adding subd. 1c. Requires the commissioner to enter into a contract with a qualified vendor or vendors to obtain and process fingerprints and photographs for background study purposes. Outlines payment and reimbursement provisions.
25	**Background studies fee schedule.** Amends § 245C.10 by adding subd. 1d. Requires the commissioner to publish a background study fee schedule by March 1 of each year, to be effective from July 1 to June 30 each year. Specifies that fees will be based on actual costs of background study administration; specifies how the fees must be published and how fees are appropriated.

Section	Description - Article 2: DHS Licensing and Background Studies

Makes this section effective July 1, 2021; requires the commissioner to publish the initial fee schedule on July 1, 2021, which will be effective September 1, 2021.

26 **Guardians and conservators.**

Amends § 245C.10, subd. 15. Modifies requirements for fees to be paid for conducting an alternative background study for appointment of a guardian or conservator.

27 **Early intensive developmental and behavioral intervention providers.**

Amends § 245C.10 by adding subd. 17. Establishes fee of no more than $20 for a background study for the purposes of early intensive developmental and behavioral intervention.

Makes this section effective the day following final enactment.

28 **Applicants, licensees, and other occupations regulated by commissioner of health.**

Amends § 245C.10 by adding subd. 18. Specifies that the applicant or license holder is responsible for paying all fees associated with background studies.

29 **Occupations regulated by MNsure.**

Amends § 245C.10 by adding subd. 20. Requires the commissioner to set fees to recover background study costs for MNsure-related studies, through an interagency agreement; specifies that fees will be deposited in the special revenue fund for the purpose of conducting background studies.

30 **Activities pending completion of background study.**

Amends § 245C.13, subd. 2. Adds personal care assistant services to list of activities prohibited prior to receipt of background study notices.

31 **Disqualification from direct contact.**

Amends § 245C.14, subd. 1. Specifies that the commissioner must disqualify an individual applying for family foster setting licensure from any position allowing direct contact with persons served, if the background study contains disqualifying information, as listed in section 245C.15, subdivision 4a (new subdivision).

Makes this section effective July 1, 2022.

32 **Disqualification from working in licensed child care centers or certified license-exempt child care centers.**

Amends § 245C.14 by adding subd. 4. Specifies that a disqualified individual must be disqualified from working in any position in a licensed child care center or certified license-exempt child care center, until the commissioner issues a notice that: (1) the

Section	Description - Article 2: DHS Licensing and Background Studies

individual is not disqualified; (2) a disqualification has been set aside; or (3) a variance has been granted.

33 **Licensed family foster setting disqualifications.**

Amends § 245C.15, by adding subd. 4a. Paragraph (a) lists felony-level convictions that permanently disqualify an individual applying for a family foster setting license.

Paragraph (b) lists additional crimes or conduct that permanently disqualify an individual applying for a family foster setting license.

Paragraph (c) specifies that an individual whose parental rights have been terminated is disqualified from family foster setting licensure for 20 years.

Paragraph (d) lists felony-level convictions that disqualify an individual applying for a family foster setting license for five years.

Paragraph (e) lists additional crimes or conduct that disqualify an individual applying for a family foster setting license for five years.

Paragraph (f) specifies that for purposes of this subdivision, a disqualification begins from: (1) the date of the alleged violation, if the individual was not convicted; (2) the date of the conviction, if the individual was convicted but not committed to the custody of the commissioner of corrections; or (3) the date of release from prison. Adds clause regarding reincarceration.

Paragraph (g) contains language regarding disqualifications for aiding and abetting, attempt, or conspiracy to commit listed offenses.

Paragraph (h) contains language regarding disqualifications for offenses in other states or countries.

Makes this section effective July 1, 2022.

34 **Determining immediate risk of harm.**

Amends § 245C.16, subd. 1. Allows the commissioner to order immediate removal of an individual from any position allowing direct contact with or access to persons receiving services, or from any position in a licensed child care center or certified license-exempt child care center, if the individual has a disqualification that is a permanent bar or the individual is a child care background study subject with a felony drug-related offense in the past five years.

35 **Findings.**

Amends § 245C.16, subd. 2. Prohibits the commissioner from making a finding that an individual requires direct, continuous supervision while providing direct contact

Section	Description - Article 2: DHS Licensing and Background Studies

services during the disqualification reconsideration request period, for a licensed child care center or certified license-exempt child care center.

36 **Time frame for notice of study results and auditing system access.**

Amends § 245C.17, subd. 1. Adds a child care center or certified license-exempt child care center to the list of facilities in which an individual must be immediately removed from direct contact or access, when notice is issued that more time is needed to complete a study.

37 **Disqualification notice to child care centers or certified license-exempt child care centers.**

Amends § 245C.17 by adding subd. 8. Requires an immediate removal notice to also include an order for a license holder to immediately remove the individual from working in any position in a child care center or certified license-exempt child care center.

38 **Obligation to remove disqualified individual from direct contact and from working in a program, facility, setting, or center.**

Amends § 245C.18. Requires a child care center or certified license-exempt child care center license holder to remove a disqualified individual from working in any position in a licensed child care center or certified license-exempt child care center, until the commissioner issues a notice that: (1) the individual is not disqualified; (2) a disqualification has been set aside; or (3) a variance has been granted.

39 **Permanent bar to set aside a disqualification.**

Amends § 245C.24, subd. 2. Prohibits the commissioner from setting aside or granting a variance for a disqualification under section 245C.15, subdivision 4a, paragraphs (a) and (b), for an individual 18 years of age or older. Allows a variance to a disqualification for an individual who is under 18 years of age when the background study is submitted.

Makes this section effective July 1, 2022.

40 **Ten-year bar to set aside disqualification.**

Amends § 245C.24, subd. 3. Removes family foster setting providers from subdivision prohibiting set asides of disqualifications for ten years.

Makes this section effective July 1, 2022.

41 **Seven-year bar to set aside disqualification.**

Amends § 245C.24, subd. 4. Removes family foster setting providers from subdivision prohibiting set asides of disqualifications for seven years.

Section	Description - Article 2: DHS Licensing and Background Studies

Makes this section effective July 1, 2022.

42 **Five-year bar to set aside disqualification; family foster setting.**

Amends § 245C.24 by adding subd. 6. Specifies that that the commissioner must not set aside a disqualification for any of the crimes or actions listed in section 245C.15, subdivision 4a, paragraph (d), committed within the past five years, for anyone 18 or older in connection with a family foster setting license. Allows the commissioner to set aside or grant a variance to a disqualification if the individual is under 18 years of age at the time the background study is submitted.

Makes this section effective July 1, 2022.

43 **NETStudy 2.0 system.**

Amends § 245C.32, subd. 1a. Makes clarifying changes related to fingerprint collection vendors.

44 **Background studies.**

Amends § 256B.0949 by adding subd. 16a. Specifies that early intensive developmental and behavioral intervention background study requirements must be met through a background study under specified sections of chapter 245C.

Makes this section effective the day following final enactment.

45 **Duties of commissioner.**

Amends § 260C.215, subd. 4. Adds paragraph requiring the commissioner of human services to establish family foster setting licensing guidelines for county and private licensing agencies; specifies that the guidelines are directives of the commissioner.

Makes this section effective July 1, 2023.

46 **Waivers and modifications; extension for 180 days.**

Amends Laws 2020, First Special Session chapter 7, section 1, as amended by Laws 2020, Third Special Session chapter 1, section 3, by adding subd. 5.

Extends the DHS waiver modifying background study requirements for 180 days after the peacetime emergency declared by the governor expires, is terminated, or is rescinded by the proper authority.

Makes this section effective the day following final enactment, or retroactively from the date the peacetime emergency ends, whichever is earlier.

Section	Description - Article 2: DHS Licensing and Background Studies
47	**Child foster care licensing guidelines.** Directs the commissioner of human services, in consultation with specified stakeholders, to develop family foster setting licensing guidelines for county and private licensing agencies, by July 1, 2023.
48	**Revisor instruction.** Instructs the revisor of statutes to renumber subdivisions in the definitions section alphabetically and correct any cross-references.
49	**Repealer.** Repeals subdivisions of 245C.10 relating to specific background study fees.

Article 3: Health Department

This article establishes or modifies Health Department programs and activities.

Section	Description - Article 3: Health Department
1	**Implementation.** Amends § 62J.495, subd. 1. Eliminates language requiring the commissioner of health to provide an update to the legislature on the development of uniform standards for interoperable electronic health records systems, as part of an annual report to the legislature.
2	**E-Health Advisory Committee.** Amends § 62J.495, subd. 2. Eliminates a requirement for the commissioner of health to issue an annual report outlining progress in implementing a statewide health information infrastructure and providing recommendations to promote adoption and effective use of health information technology. Also extends the subdivision to June 30, 2031 (under current law this subdivision, which establishes the e-Health Advisory Committee, expires June 30, 2021). This section is effective the day following final enactment.
3	**Interoperable electronic health record requirements.** Amends § 62J.495, subd. 3. Strikes a requirement that a health data intermediary to which an electronic health record system must be connected, must be state-certified. (State certification of health data intermediaries is being eliminated in another section.)

Section	Description - Article 3: Health Department

4 **Coordination with national HIT activities.**

Amends § 62J.495, subd. 4. Eliminates a reference to a specific federal HIT strategic plan with which the statewide interoperable health information infrastructure plan must be consistent and instead requires the plan to be consistent with updated federal plans. Eliminates duties of the commissioner to help develop and support health information technology regional extension centers, to provide supplemental information on best practices gathered by regional centers, and to monitor and respond to development of quality measures. Also strikes a reference to a report to the legislature being eliminated in another subdivision.

5 **Definitions.**

Amends § 62J.497, subd. 1. In a subdivision defining terms for the electronic prescription drug program, amends the definition of NCPFP Formulary and Benefits Standard by removing a reference to the 2005 implementation guide version and instead referring to the most recent version of the standard or to the most recent version adopted by CMS for e-prescribing under Medicare Part D. Also amends the definition of NCPDP SCRIPT Standard by removing a reference to the 2005 implementation guide version.

6 **Standards for electronic prescribing.**

Amends § 62J.497, subd. 3. In a subdivision providing standards for electronic prescribing, strikes a list of specific transactions that must be conducted using the NCPDP SCRIPT Standard.

7 **Health information exchange.**

Amends § 62J.498. Eliminates certain definitions and establishes an additional duty for the commissioner of health regarding health information exchange oversight.

Subd. 1. Definitions. Eliminates the following definitions for sections governing health information exchanges, certificates of authority to provide HIE services, and enforcement authority: HITECH Act, meaningful use, meaningful use transaction, and state-certified health data intermediary. Also removes references to health information exchange service providers being state-certified.

Subd. 2. Health information exchange oversight. In a subdivision establishing duties of the commissioner to protect the public interest, adds a duty of requiring health information exchange service providers to provide information to meet statutory requirements.

Section	Description - Article 3: Health Department

8 **Certificate of authority to provide health information exchange services.**

Amends § 62J.4981. Eliminates a requirement that health data intermediaries must be certified by the commissioner, and makes conforming changes.

Subd. 1. Authority to require organizations to apply. Eliminates a requirement for health data intermediaries to apply to the commissioner for certificates of authority.

Subd. 2. Certificate of authority for health data intermediaries. Strikes a subdivision requiring health data intermediaries to be certified by the commissioner in order to operate as a health data intermediary in the state and establishing criteria to obtain a certificate of authority.

Subd. 3. Certificate of authority for health information organizations. Strikes references to state-certified health data intermediaries to conform with subdivision 2.

Subd. 4. Application for certificate of authority for health information organizations. Modifies terms used, eliminates unnecessary language, and modifies cross-references to conform with the elimination of a requirement for health data intermediaries to be certified.

Subd. 5. Reciprocal agreements between health information organizations. Strikes language requiring reciprocal agreements between health information organizations and health data intermediaries to meet the requirements in this subdivision. Strikes a reference to state-certified health data intermediary to conform with elimination of a requirement for health data intermediaries to be certified. Also strikes references to meaningful use.

9 **Enforcement authority; compliance.**

Amends § 62J.4982. In a section governing enforcement and compliance for health information organizations, eliminates a requirement that health data intermediaries must be certified by the commissioner, eliminates the commissioner's authority to impose penalties on health data intermediaries, eliminates application and annual certificate fees for health data intermediaries, and modifies terms used to conform with elimination of the requirement for health data intermediaries to be certified by the commissioner.

10 **Support for state health care purchasing and performance measurement.**

Amends § 62J.63, subd. 1. Eliminates language requiring the commissioner of health to establish and administer a Center for Health Care Purchasing Improvement but retains certain functions of the center and assigns them to the commissioner of health.

Section	Description - Article 3: Health Department

11 **Duties; scope.**

Amends § 62J.63, subd. 2. Eliminates language authorizing the commissioner to appoint staff for the Center for Health Care Purchasing Improvement. Also eliminates the following duties: initiating projects to develop plan designs for state health care purchasing; conducting policy audits of state programs; consulting with the Health Economics Unit regarding reports and assessments of the health care marketplace; consulting with the Department of Commerce regarding regulatory issues and legislative initiatives; working with DHS and CMS to address federal requirements for health care purchasing and conformity issues; assisting MCHA in purchasing strategies; and convening agency medical directors for advice and collaboration. Allows the commissioner to evaluate current administrative simplification strategies.

12 **Encounter data.**

Amends § 62U.04, subd. 4. Requires health plan companies and third-party administrators to submit encounter data to the all-payer claims database on a monthly basis, rather than every six months as in current law. Notwithstanding the data classification as private data on individuals or nonpublic data, allows provider data held by the all-payer claims database to be released or published as authorized in subdivision 11, which specifies authorized uses of data in the database.

13 **Pricing data.**

Amends § 62U.04, subd. 5. Notwithstanding the data classification of pricing data as nonpublic, allows pricing data held by the all-payer claims database to be released or published for the purposes specified in subdivision 11, which specifies authorized uses of data in the database.

14 **Restricted uses of the all-payer claims data.**

Amends § 62U.04, subd. 11. Modifies data from the all-payer claims database that is available for use and that may be published, to: (1) allow public use files compiled by the commissioner to identify the rendering or billing hospital, clinic, or medical practice; and (2) allow the commissioner to publish the results of authorized uses under this subdivision in a way that identifies hospitals, clinics, and medical practices, provided no individual health professionals are identified and the commissioner determines the data is accurate, valid, and suitable for publication.

15 **Procedure.**

Amends § 103H.201, subd. 1. Modifies a provision authorizing the commissioner of health to adopt health risk limits for substances degrading groundwater. For toxicants that are known or probable carcinogens, requires the commissioner to use a quantitative estimate of a chemical's carcinogenic potency either: (1) published by the federal Environmental Protection Agency; or (2) determined by the commissioner to have undergone thorough scientific review. (Under current law the quantitative

Section **Description - Article 3: Health Department**

estimate must be both published by the EPA and determined by the commissioner to have undergone thorough scientific review.)

16 **Distribution of COVID-19 vaccines.**

Adds § 144.066. Directs the commissioner of health to distribute COVID-19 vaccines according to this section.

Subd. 1. Definitions. Defines the following terms for this section and sections 144.067 to 144.069: commissioner, COVID-19 vaccine, department, disproportionately impacted community, local health department, and mobile vaccination vehicle.

Subd. 2. Distribution. Requires the commissioner to establish and maintain partnerships or agreements with the listed entities to administer COVID-19 vaccines throughout the state. Also allows COVID-19 vaccines to be administered via mobile vaccination vehicles.

Subd. 3. Second dose or booster. States that a registered vaccine provider should be directed by the department during the registration process to assist vaccine recipients with scheduling an appointment for any required second dose or booster.

Subd. 4. Nondiscrimination. Provides that nothing in section 144.066 to 144.069 shall be construed to allow or require denial of a benefit or opportunity based on certain characteristics.

This section is effective the day following final enactment.

17 **Equitable COVID-19 vaccine distribution.**

Adds § 144.067. Requires the commissioner of health to establish positions to continue COVID-19 vaccine equity and outreach activities, establishes education and outreach and community assistance programs, and requires establishment of metrics to measure equitable distribution of COVID-19 vaccines.

Subd. 1. COVID-19 vaccination equity and outreach. Requires the commissioner of health to establish positions to work on COVID-19 vaccine equity and outreach and to address disparities in COVID-19 vaccination rates. Requires this work to be managed by a director who has a leadership role in the department's COVID-19 response.

Subd. 2. Vaccine education and outreach campaign; direct delivery of information. Requires the commissioner to administer a COVID-19 vaccine education and outreach campaign to directly provide information on the listed

Section **Description - Article 3: Health Department**

topics to members of disproportionately impacted communities. Specifies how the information must be delivered.

Subd. 3. Vaccine education and outreach campaign; mass media. Requires the commissioner to administer a mass media campaign to provide COVID-19 vaccine education and outreach on the listed topics to members of disproportionately impacted communities.

Subd. 4. Community assistance. Requires the commissioner to administer a community assistance program to help members of disproportionately impacted communities arrange and prepare to obtain COVID-19 vaccines and to help transportation-limited individuals obtain vaccines.

Subd. 5. Equitable distribution of COVID-19 vaccines. Requires the commissioner to establish a set of metrics to measure the equitable distribution of COVID-19 vaccines, and to set and update goals for vaccine distribution that are focused on equity.

Subd. 6. Expiration of programs. Provides that the vaccine education and outreach programs and the community assistance program 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 from COVID-19.

This section is effective the day following final enactment.

18 **Mobile vaccination program.**

Adds § 144.068. Requires the commissioner to administer a mobile vaccination program using mobile vaccination vehicles.

Subd. 1. Administration. Directs the commissioner to administer a mobile vaccination program in which mobile vaccination vehicles are deployed to communities around the state to vaccinate individuals. Requires mobile vaccination vehicles to be deployed to communities to improve access to vaccines.

Subd. 2. Eligibility. Provides that all individuals in a community to which a mobile vaccination vehicle is deployed are eligible to receive COVID-19 vaccines from the vehicle.

Subd. 3. Staffing. Requires mobile vaccination vehicles to be staffed according to CDC guidelines and allows them to be staffed with additional personnel based on local needs.

Subd. 4. Second doses. Requires staff of a mobile vaccination vehicle to assist vaccine recipients receiving a first dose to schedule a second dose or booster,

Section	Description - Article 3: Health Department

and requires the commissioner, to the extent possible, to deploy mobile vaccination vehicles in a way that allows vaccine recipients to receive second doses or boosters from the mobile vaccination vehicle.

Subd. 5. Expiration. Directs the commissioner to 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 from the spread of COVID-19.

This section is effective the day following final enactment.

19 **COVID-19 vaccination plan and data; reports.**

Adds § 144.069. Requires the commissioner of health to publish metrics for equitable COVID-19 vaccine distribution and implementation protocols for equitable COVID-19 vaccine distribution. Also requires weekly publication of data on COVID-19 vaccines and quarterly reports on funding for certain COVID-19 activities.

Subd. 1. COVID-19 vaccination plan; implementation protocols. Requires the commissioner to publish the equity metrics and goals for equitable COVID-19 vaccine distribution and implementation protocols to address disparities in COVID-19 vaccination rates in certain communities.

Subd. 2. Data on COVID-19 vaccines. Requires the commissioner, on a weekly basis, to publish the specified data related to COVID-19 vaccines.

Subd. 3. Quarterly reports. On at least a quarterly basis while funds are available, requires the commissioner to report to certain members of the legislature on funds distributed to local health departments for COVID-19 activities and funds expended to implement sections 144.066 to 144.069.

This section is effective the day following final enactment.

20 **Resident reimbursement case mix classifications.**

Amends § 144.0724, subd. 1. Modifies a term used in a subdivision requiring the commissioner of health to establish case mix classifications for residents of nursing homes and boarding care homes.

21 **Definitions.**

Amends § 144.0724, subd. 2. In a subdivision defining terms for a section on case mix classifications, makes a technical change to the definition of minimum data set and modifies the definition of activities of daily living.

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22	**Resident reimbursement case mix classifications beginning January 1, 2012.** Amends § 144.0724, subd. 3a. In a subdivision establishing requirements for case mix classifications, modifies a term used and removes a reference to the Case Mix Classification Manual for Nursing Facilities.
23	**Short stays.** Amends § 144.0724, subd. 5. Provides that a facility is not required to submit an admission assessment for a resident admitted to and discharged from the facility on the same day. Provides that when an admission assessment is not submitted, the case mix classification will be the rate with a case mix index of 1.0.
24	**Notice of reimbursement case mix classification.** Amends § 144.0724, subd. 7. In a subdivision governing notice from the commissioner of health to a nursing facility regarding case mix classifications established for residents, makes technical changes and changes in terminology and requires the notice of modified assessment to be provided to the facility within 3 business days after distribution of the classification notice to the resident.
25	**Request for reconsideration of resident classifications.** Amends § 144.0724, subd. 8. In a subdivision governing requests for reconsideration of resident classifications, allows reconsideration of any items changed during the audit process, reorganizes the subdivision for requests initiated by the resident or a representative and for requests submitted by the facility, and makes technical changes. For requests initiated by the resident or a representative, eliminates language specifying what must accompany the reconsideration request, reorganizes language specifying what the facility must submit, and specifies the consequence when a facility fails to provide the required information. For requests initiated by the facility, requires the facility to provide the resident or a representative with notice of the request, requires the request to be submitted within a certain timeframe, and permits rather than requires the commissioner to deny the reconsideration request if the facility fails to provide the required information. Establishes requirements for transmitting the reconsideration classification notice to the nursing facility and to the resident or representative.
26	**Audit authority.** Amends § 144.0724, subd. 9. In a subdivision requiring the commissioner to ensure the accuracy of resident assessments through audits, reviews of records, and interviews, strikes language requiring the commissioner to make the results of the audit available to the facility, requires distribution of the audit classification notice to the facility and the resident or representative within certain timeframes if the audit results in a case mix classification change, and specifies what the notice must include.

Section	Description - Article 3: Health Department
27	**Appeal of nursing facility level of care determination.** Amends § 144.0724, subd. 12. Strikes obsolete language.
28	**Initial and annual fee.** Amends § 144.1205, subd. 2. A new paragraph (a) requires an entity obtaining a license for radioactive material or source or special nuclear material, to pay an initial fee upon issuance of the initial license. Paragraph (b) consolidates fee categories, establishes additional fee categories for facilities with multiple locations, modifies the names of fee categories, and modifies annual fee amounts for licensure for radioactive material or source or special nuclear material.
29	**Initial and renewal application fee.** Amends § 144.1205, subd. 4. Specifies that the application fees due under this subdivision are for initial applications for licensure and to renew applications for licensure. Consolidates fee categories, deletes certain fee categories, and modifies application fees for licensure for radioactive material or source or special nuclear material.
30	**Reciprocity fee.** Amends § 144.1205, subd. 8. Changes the application fee for reciprocal recognition of a radioactive materials license issued by another state or the federal Nuclear Regulatory Commission, from $1,200 to $2,400.
31	**Fees for license amendments.** Amends § 144.1205, subd. 9. Changes the fee to amend a license for radioactive material, from $300 to $600.
32	**Fees for general license registrations.** Adds subd. 10 to § 144.1205. Establishes an annual registration fee of $450 for the registration of generally licensed devices (devices that contain radioactive material and that are designed to detect, measure, or control thickness, density, level, interface location, radiation, leakage, or chemical composition, or designed to produce light or an ionizing atmosphere).
33	**Duty to perform testing.** Amends § 144.125, subd. 1. Increases the per-specimen fee for testing under the newborn screening program from $135 to $177. (The newborn screening program tests newborns soon after birth for rare disorders of metabolism, hormones, the immune system, blood, breathing, digestion, hearing, or the heart.)

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34 **Dignity in pregnancy and childbirth.**

Adds § 144.1461. Requires hospitals that provide obstetric care and birth centers to provide continuing education on anti-racism training and implicit bias.

Subd. 1. Citation. Provides that this section may be cited as the Dignity in Pregnancy and Childbirth Act.

Subd. 2. Continuing education requirement. Paragraph (a) requires hospitals with obstetric care and birth centers to provide continuing education on anti-racism training and implicit bias. Requires the continuing education to be evidence-based and lists criteria that it must include.

Paragraph (b) requires hospitals and birth centers to also provide an annual refresher course that reflects current trends on race, culture, identity, and anti-racism principles and institutional implicit bias.

Paragraph (c) requires hospitals with obstetric care and birth centers to develop continuing education materials on anti-racism training and implicit bias that must be provided to direct care employees and contractors who routinely care for pregnant or postpartum women.

Paragraph (d) requires hospitals with obstetric care and birth centers to coordinate with health-related licensing boards to obtain continuing education credits for the training and materials required by this section. Also requires the commissioner to monitor compliance with this section and requires initial training to be completed by December 31, 2022.

Paragraph (e) requires hospitals with obstetric care and birth centers to provide a certificate of training completion upon request, and allows a facility to accept the training certificate from another facility for a provider who works in more than one facility.

35 **Establishment; membership.**

Amends § 144.1481, subd. 1. Adds an oral health professional to the membership of the Rural Health Advisory Committee.

36 **International medical graduate primary care residency grant program and revolving account.**

Amends § 144.1911, subd. 6. Adds general surgery residency programs to the types of primary care residency programs eligible for a grant to support residency positions designated for Minnesota immigrant physicians willing to serve in rural or underserved areas of the state.

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37 **Homeless youth.**

Adds subd. 12 to § 144.212. Adds a definition of homeless youth to definitions that apply to vital records sections.

38 **Data about births.**

Amends § 144.225, subd. 2. Under current law, data on the birth of a child born to a woman not married to the child's father when the child was conceived or born is classified as confidential data but may be disclosed to certain persons, including to the child if the child is 16 or older. This section allows this data to be disclosed to the child if the child is homeless youth, and does not require the homeless youth to be 16 or older.

39 **Certified birth or death record.**

Amends § 144.225, subd. 7. Adds a cross-reference to section 144.2255, to exempt homeless youth from paying the required fees to obtain a certified birth record. Also makes the following changes to who may obtain an individual's certified birth or death record:

- removes a requirement that an individual requesting a certified record has a tangible interest in the record and defining tangible interest, and instead just lists individuals who may obtain a certified record;
- removes from the list of individuals who may obtain a certified record, the party responsible for filing the record; and
- provides that for an attorney to obtain a certified record, the attorney must represent the subject of the record or another individual otherwise authorized in clause (1) to obtain a record (under current law any attorney may obtain a certified record).

40 **Certified birth record for homeless youth.**

Adds § 144.2255. Establishes procedures and documentation requirements for a homeless youth to obtain a certified birth record.

Subd. 1. Application; certified birth record. Allows a subject of a birth record who is a homeless youth in this or another state to apply to the state registrar or a local issuance office for a certified birth record. Lists what a homeless youth must submit to the state registrar or local issuance office.

Subd. 2. Statement verifying subject is a homeless youth. If a homeless youth submits a statement from another individual to verify that the youth is a homeless youth, lists information that must be included in the statement, and requires the individual providing the statement to also provide a copy of the individual's employment identification.

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Subd. 3. Expiration; reissuance. If a subject of a birth record obtains a birth record in part using a statement from another individual to verify that the subject is a homeless youth, makes the birth record expire 6 months after issuance. Allows the subject of such a birth record to surrender the expired record to the state registrar or local issuance office and obtain another birth record. Provides that all birth records obtained under this subdivision expire 6 months after issuance. If the subject does not surrender the expired birth record, requires the subject to apply for a certified record according to subdivision 1.

Subd. 4. Fees waived. Prohibits the state registrar or local issuance office from charging a fee to a homeless youth for issuing a certified birth record or statement of no vital record found under this section.

Subd. 5. Data practices. Classifies as private data on individuals, a statement from the subject of the birth record that he or she is a homeless youth, and a statement from another individual verifying that the subject of the birth record is a homeless youth.

Makes this section effective the day following final enactment for applications for and the issuance of certified birth records on or after January 1, 2022.

41 **Transaction fees.**

Adds subd. 7 to § 144.226. Allows the state registrar and agents to charge a convenience fee and a transaction fee for electronic transactions and transactions by the telephone or the Internet for distribution of vital records.

42 **Birth record fees waived for homeless youth.**

Adds subd. 8 to § 144.226. Amends a section governing fees for the issuance of vital records to exempt a homeless youth from payment of any fees required under this section to obtain a certified birth record or statement of no record found.

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.

43 **Routine inspections; presumption.**

Amends § 144.55, subd. 4. In a subdivision governing the commissioner of health's authority to inspect hospitals, requires the commissioner to conduct hospital inspections as needed to determine whether a hospital or hospital corporate system continues to satisfy the conditions on which a moratorium exception was granted.

44 **Suspension, revocation, refusal to renew.**

Amends § 144.55, subd. 6. Prohibits the commissioner from renewing licenses for hospital beds issued according to a hospital construction moratorium exception if the

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commissioner finds the hospital or hospital corporate system is not satisfying the conditions included in the exception.

This section is effective for license renewals occurring on or after July 1, 2021.

45 **Restricted construction or modification.**

Amends § 144.551, subd. 1. Amends an existing exception to the hospital construction moratorium to require hospital beds transferred from a closed hospital to another site or complex in a hospital corporate system to be first used to replace the beds that had been used in the closed hospital for mental health services and substance use disorder services, before transferring remaining beds for any other purpose. Also adds two additional exceptions to the hospital construction moratorium to:

- allow Regions to add 45 licensed beds. This exception is effective contingent on Regions adding the 15 licensed mental health beds authorized in clause (28), designating 5 of the 45 beds in the current exception for inpatient mental health, and agreeing to not use revenue recapture; and
- allow the addition of licensed beds to primarily provide mental health services or substance use disorder services. In order to be eligible to add beds, a hospital must have an emergency department, not be a hospital that solely treats adults for mental illness or substance use disorders, and make the beds available to MA and MinnesotaCare enrollees.

46 **Monitoring.**

Adds subd. 5 to § 144.551. Requires the commissioner to monitor the addition of beds and establishment of new hospitals according to exceptions established under this section. Requires hospitals and hospital corporate systems to annually report to the commissioner on how the hospital or system continues to satisfy the conditions included in the exception.

47 **Facility or campus closings, relocating services, or ceasing to offer certain services; patient relocations.**

Amends § 144.555.

Subd. 1. Notice of closing or curtailing operations; facilities other than hospitals. Provides that the existing law requiring notice to the commissioner of health when a facility voluntarily plans to cease or curtail operations applies to facilities other than hospitals. (Notice requirements for hospitals are moved from this subdivision to the new subdivision 1a.)

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Subd. 1a. Notice of closing, curtailing operations, relocating services, or ceasing to offer certain services; hospitals. Requires the controlling persons of a hospital or hospital campus to notify the commissioner of health at least nine months before the hospital or hospital campus ceases or curtails operations, relocates the provision of health services to another hospital or hospital campus, or ceases to offer maternity and newborn care services, ICU services, inpatient mental health services, or inpatient substance use disorder services. Requires controlling persons of a hospital or campus to comply with the right of first refusal provisions in section 144.556.

Subd. 1b. Public hearing. Upon receiving notice under subdivision 1a, requires the commissioner to conduct a public hearing on the cessation of operations, curtailment of operations, or relocation or cessation of services. Requires the public hearing to be held in the community where the facility or campus is located at least six months before the scheduled change, and lists what must be addressed at the public hearing.

Subd. 2. Penalty. Provides that failure to notify the commissioner according to subdivision 1a or to participate in a public hearing according to subdivision 1b may result in the commissioner of health issuing a correction order against the facility.

48 **Right of first refusal for hospital or hospital campus.**

Adds § 144.556. Provides a local unit of government with a right of first refusal to purchase a hospital or hospital campus before the hospital or campus is sold or conveyed to another party, or is closed.

Subd. 1. Prerequisite before sale, conveyance, or ceasing operations of hospital or hospital campus. Before the controlling persons of a hospital sell, convey, or offer to sell or convey a hospital or hospital campus or cease operations of the hospital or campus, requires the controlling persons to first make a good faith offer to sell or convey the hospital or campus to a local unit of government where the hospital or campus is located.

Subd. 2. Offer. Prohibits the offer to sell or convey the hospital or campus from being at a price that exceeds the hospital's or campus's current fair market value, requires the offer to be accepted or declined within 60 days after receipt, and provides that if the party to whom the offer is made does not respond within 60 days, the offer is deemed declined.

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49 **Lead hazard reduction.**

Amends § 144.9501, subd. 17. Amends a definition of lead hazard reduction to allow it to take place at any location where lead hazards are identified (current law allows it to take place at a residence, child care facility, school, or playground).

50 **Reports of blood lead analysis required.**

Amends § 144.9502, subd. 3. Amends a subdivision establishing requirements for medical clinics, laboratories, and facilities to report results of blood lead analyses to the commissioner, to specify that the commissioner may prescribe the manner in which a clinic, laboratory, or facility must report the results.

51 **Lead risk analysis.**

Amends § 144.9504, subd. 2. Makes the following changes to a subdivision governing lead risk assessments conducted by assessing agencies:

- expands the locations where an assessing agency must conduct a lead risk assessment to include child care facilities, playgrounds, schools, and other locations where lead hazards are suspected (under current law assessing agencies must conduct lead risk assessments of residences);
- requires a lead risk assessment to be conducted within ten working days if a child has a venous blood lead level of ten micrograms of lead per deciliter of blood, rather than 15 micrograms as in current law;
- requires a lead risk assessment to be conducted within 20 working days if a child or pregnant female at a location where lead hazards are suspected has a venous blood lead level of five micrograms of lead per deciliter of blood; and
- provides that lead risk assessments must be conducted if a child under 18 has one of the listed blood lead levels, rather than if a child age 6 or under has one of the listed blood lead levels.

52 **Lead orders.**

Amends § 144.9504, subd. 5. Expands an assessing agency's authority to order lead hazard reduction. If an assessing agency finds a lead hazard at a property originated from another source location, allows the assessing agency to order the responsible person of the source location to: (1) perform lead hazard reduction at the lead risk assessment site; and (2) remediate conditions at the source location that allowed the lead to migrate from the source location.

53 **Assisted living facility.**

Amends § 144G.08, subd. 7, as further amended. Amends the definition of assisted living facility for the chapter governing assisted living facility licensure to mean an establishment where an operating person or legal entity, either directly or through

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one of the specified arrangements, provides accommodations and services to one or more adults in the facility. Also strikes language that covered settings are not included in the definition of assisted living facility.

54 **Services for residents with dementia.**

Amends § 144G.84. Amends requirements for access to outdoor space for residents of assisted living facilities with dementia care, to require existing housing with services establishments that obtain an assisted living facility license to provide residents with regular access to outdoor space and to require a licensee with new construction or a new licensee to provide regular access to secured outdoor space on the premises of the facility.

55 **Home visiting for pregnant women and families with young children.**

Adds §145.87.

Subd. 1. Definitions. Defines the following terms for this section: evidence-based home visiting program, evidence-informed home visiting program, health equity, and promising practice home visiting program.

Subd. 2. Grants for home visiting. Directs the commissioner of health to award grants to community health boards, nonprofit organizations, and tribal nations to start up or expand voluntary home visiting programs. Grant money must be used to establish evidence-based, evidence-informed, or promising practice home visiting programs that address health equity, use community-driven strategies, and serve families with young children or pregnant women who are high risk or have high needs.

Subd. 3. Grant prioritization. Directs the commissioner to prioritize grants to programs seeking to expand home visiting services with community or regional partnerships. Requires that at least 75% of the grant money awarded each grant cycle supports evidence-based programs and up to 25% supports evidence-informed or promising practice programs.

Subd. 4. Administrative costs. Allows the commissioner to use up to 7% of the annual appropriation for training and technical assistance and to administer and evaluate the program, and allows the commissioner to contract for training, capacity-building, technical assistance, and evaluation support.

Subd. 5. Use of state general fund appropriations. Provides that appropriations dedicated to starting up or expanding evidence-based home visiting programs must be awarded according to this section beginning July 1, 2021. Provides that this section does not govern grant awards of federal funds for home visiting

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programs or grant awards of state funds dedicated to nurse-family partnership home visiting programs.

56 **Food benefits.**

Amends § 145.893, subd. 1. Changes a term used, from vouchers to food benefits, in a subdivision authorizing eligible individuals to receive benefits to purchase nutritional supplements under WIC.

57 **State commissioner of health; duties, responsibilities.**

Amends § 145.894. Allows local health agencies to issue WIC food benefits three times per month, instead of twice per month as permitted under current law. Strikes obsolete language.

58 **Food benefits.**

Amends § 145.897. In a section governing foods eligible for purchase under WIC, provides that the federal Department of Agriculture, not the commissioner, determines allowable foods; changes a term; and strikes language listing examples of allowable foods.

59 **Food benefits for organics.**

Amends § 145.899. In a section allowing WIC food benefits to be used to buy cost-neutral organic allowable foods, changes a term used.

60 **Access to data.**

Amends § 145.901, subd. 2. Amends a subdivision governing access to data for maternal death studies to specify that the commissioner has access to the names of providers, clinics, or other health services where care was received before, during, or related to the pregnancy or death. Also allows the commissioner to access records maintained by medical examiners, coroners, and hospitals and hospital discharge data; allows the commissioner to request from a coroner or medical examiner the names of health care providers that provided prenatal, postpartum, or other health services; and allows the commissioner to access DHS data to evaluate welfare systems, and to request and receive law enforcement reports or incident reports.

61 **Classification of data.**

Amends § 145.901, subd. 4. Amends a subdivision classifying data held by the commissioner for purposes of maternal death studies to state that data provided by the commissioner of human services to the commissioner of health under this section retains the same classification as when held by the commissioner of human services.

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62 **Severe maternal morbidity studies.**

Adds § 145.9013. Authorizes the commissioner of health to conduct maternal morbidity studies to help with planning for and evaluation of existing systems and to reduce preventable adverse maternal outcomes in the state.

Subd. 1. Purpose. Allows the commissioner of health to conduct maternal morbidity studies for the specified purposes. Defines maternal morbidity as severe maternal morbidity as defined by the CDC and specifies it includes an unexpected outcome of labor or delivery that results in significant short- or long-term consequences to a woman's health. (The CDC uses International Classification of Diseases diagnosis and procedure codes to identify delivery hospitalizations that have severe maternal morbidity indicators. Some severe maternal morbidity indicators include acute myocardial infarction, aneurysm, acute renal failure, eclampsia, and blood products transfusion.)

Subd. 2. Access to data. Paragraph (a) allows the commissioner to access the medical data and health records of a woman who experienced one or more maternal morbidities during pregnancy or within 12 months of the end of a pregnancy and occurring on or after January 1, 2015. Allows the commissioner to access the names of providers and clinics where care was received before, during, or related to the pregnancy, and allows the commissioner to access the records of certain programs and services to obtain the name and location of services received by the data subject.

Paragraph (b) requires the entity with the data listed in paragraph (a) to provide the commissioner with the information requested by the commissioner in a time and manner designated by the commissioner. Allows the entity to charge a fee for providing the data.

Paragraph (c) requires the commissioner to inform the data subject about collection of the subject's data under this section, once the commissioner determines the data subject meets the criteria for a maternal morbidity review. At any time during the review process, allows the data subject to request that the commissioner remove the data subject's personal identifying information from data the commissioner obtains, and requires the commissioner to comply with such requests.

Paragraph (d) allows the data subject to voluntarily participate in an informant interview and allows the commissioner to compensate the data subject for time and other interview expenses.

Paragraph (e) allows the commissioner to access DHS data to assist with the evaluation of welfare systems to reduce preventable maternal morbidities.

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Subd. 3. Management of records. After the commissioner collects all data about a maternal morbidity subject needed to perform the study, requires the commissioner to transfer certain data from the source records to separate records, and to then destroy the source records.

Subd. 4. Classification of data. Classifies data provided to the commissioner to carry out maternal morbidity studies as confidential data on individuals or confidential data on decedents. States that this information shall not be subject to discovery or introduction into evidence, but provides the information otherwise available from an original source is not immune from discovery or barred from introduction into evidence. Makes summary data on maternal morbidity studies public, and states that data provided by the commissioner of human services to the commissioner of health under this section retains the same classification as when held by the commissioner of human services.

63 **Analog.**

Amends § 152.01, subd. 23. Amends the definition of analog in the chapter governing drugs and controlled substances, to specify that analog does not include marijuana or nonsynthetic tetrahydrocannabinols.

This section is effective August 1, 2021, and applicable to crimes committed on or after that date.

64 **Schedule I.**

Amends § 152.02, subd. 2. Removes marijuana and nonsynthetic tetrahydrocannabinols from Schedule I of controlled substances. (Substances in Schedule I are those with no currently accepted medical use, a lack of accepted safety for use under medical supervision, and a high potential for abuse.)

This section is effective August 1, 2021, and applicable to crimes committed on or after that date.

65 **Schedule II.**

Amends § 152.02, subd. 3. Adds marijuana and nonsynthetic tetrahydrocannabinols to Schedule II of controlled substances. (Substances in Schedule II are those with a high potential for abuse, with use potentially leading to severe psychological or physical dependence.)

This section is effective August 1, 2021, and applicable to crimes committed on or after that date.

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66	**Prescription requirements for Schedule II controlled substances.** Amends § 152.11, subd. 1a. As a conforming change to moving marijuana from Schedule I to Schedule II, exempts medical cannabis from the requirement that a Schedule II controlled substance must be dispensed according to a prescription (health care practitioners do not prescribe medical cannabis under the medical cannabis program).
67	**Exception.** Adds subd. 5 to § 152.11. As a conforming change to moving marijuana from Schedule I to Schedule II, provides that marijuana and tetrahydrocannabinols are not considered Schedule II controlled substances for purposes of a section establishing prescription requirements for controlled substances.
68	**Exception.** Adds subd. 6 to § 152.12. Provides that marijuana and tetrahydrocannabinols are not considered Schedule II controlled substances for purposes of a section governing the prescribing, dispensing, administration, and sale of controlled substances.
69	**Limits on applicability.** Amends § 152.125, subd. 3. Provides that a section governing the prescription and administration of controlled substances for intractable pain does not apply to medical cannabis.
70	**Hemp processor.** Adds subd. 5c to § 152.22. Adds a definition of hemp processor to the medical cannabis statutes.
71	**Medical cannabis.** Amends § 152.22, subd. 6. Amends the definition of medical cannabis for the medical cannabis program to allow delivery of medical cannabis via combustion of dried raw cannabis. This section is effective the earlier of (1) March 1, 2022, or (2) a date by which rules on combustion of dried raw cannabis are in effect and independent laboratories are able to perform the required tests of dried raw cannabis.
72	**Registered designated caregiver.** Amends § 152.22, subd. 11. Amends the definition of registered designated caregiver for the medical cannabis program to remove a requirement that a health care practitioner identify a patient as needing assistance in administering or obtaining medical cannabis due to a disability.

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73 **Limitations.**

Amends § 152.23. States that the medical cannabis statutes do not permit, or prevent the imposition of penalties for, combusting medical cannabis in any of the listed locations or where the smoke would be inhaled by a minor child.

74 **Rulemaking.**

Amends § 152.26. Allows the commissioner to adopt or amend rules to implement the addition of dried raw cannabis as an allowable form of medical cannabis, allows the commissioner to adopt rules using the procedure to adopt exempt rules, and provides that the two-year limit on the effect of such rules does not apply to these rules.

This section is effective the day following final enactment.

75 **Patient application.**

Amends § 152.27, subd. 3. Removes a reference in the medical cannabis statutes to a health care practitioner determining, as part of the patient application, that the patient needs assistance in administering or obtaining medical cannabis due to a disability.

76 **Registered designated caregiver.**

Amends § 152.27, subd. 4. In the medical cannabis statutes governing registered designated caregivers, removes a requirement that a health care practitioner must certify that a patient is disabled and therefore needs assistance in administering or obtaining medical cannabis. Allows a registered designated caregiver to be caregiver for up to six patients at once (rather than one patient as in current law), and counts patients who live in the same residence as one patient.

77 **Patient enrollment.**

Amends § 152.27, subd. 6. Under current law a patient enrolled in the registry program whose enrollment is revoked for violating specified patient duties or committing certain prohibited acts is permanently prohibited from enrollment in the medical cannabis program. This section strikes language making this conduct a ground for denying a patient's enrollment, and instead allows a patient to apply for reenrollment 12 months after the patient's enrollment was revoked. Also requires the commissioner to establish a registry verification system, instead of a registry verification as in current law, and strikes obsolete language regarding approval of applications.

78 **Health care practitioner duties.**

Amends § 152.28, subd. 1. Deletes from the list of health care practitioner duties under the medical cannabis statutes, the duty of determining whether a patient is

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disabled and needs assistance administering or obtaining medical cannabis due to that disability.

79 **Manufacturer; requirements.**

Amends § 152.29, subd. 1. Allows a medical cannabis manufacturer to acquire hemp products produced by a hemp processor licensed by the commissioner of agriculture under chapter 18K. (Under current law a manufacturer is only authorized to acquire hemp from a hemp grower.) Allows a manufacturer to manufacture or process hemp products into an allowable form of medical cannabis, and makes hemp products subject to the quality control, security, testing, and other requirements that apply to medical cannabis. Requires a manufacturer's operating documents to include procedures for the delivery and transportation of hemp products between hemp processors and manufacturers, and requires a manufacturer to verify that a hemp processor is licensed under chapter 18K before acquiring hemp products from the processor.

80 **Manufacturer; distribution.**

Amends § 152.29, subd. 3. Modifies requirements for distribution of medical cannabis, to:

- allow pharmacist consultations to occur by telephone or other remote means, in addition to by videoconference as permitted under current law (consultations by telephone or other remote means are currently permitted by executive order during the peacetime emergency);
- eliminate a requirement that the pharmacist consultation occur when the patient is at the distribution facility;
- provide that a pharmacist consultation is not required when the manufacturer is distributing medical cannabis according to a patient-specific dosage plan and is not modifying the dosage or product; and
- specify that medical cannabis in dried raw cannabis form shall be distributed only patients age 21 or older or their caregivers.

Paragraph (e) is effective the earlier of (1) March 1, 2022, or (2) a date by which rules on combustion of dried raw cannabis are in effect and independent laboratories are able to perform the required tests of dried raw cannabis.

81 **Distribution to recipient in a motor vehicle.**

Adds subd. 3b to § 152.29. Allows a manufacturer to distribute medical cannabis to a patient, registered designated caregiver, or other caregiver who is at the distribution facility but remains in a motor vehicle, provided the requirements in the subdivision are met regarding the distribution of medical cannabis and payment. (Dispensing

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medical cannabis to patients and caregivers who remain in their vehicles is currently permitted by executive order during the peacetime emergency.)

82 **Disposal of medical cannabis plant root balls.**

Adds subd. 3c to § 152.29. An administrative rule currently requires medical cannabis manufacturers to render plant material waste unusable and unrecognizable by grinding the waste and incorporating it with other solid waste. This section exempts manufacturers from being required to grind medical cannabis plant root balls or to incorporate the root balls with other solid waste before transporting them to another location for disposal.

83 **Data practices.**

Amends § 152.31. Allows the commissioner of health to execute data sharing arrangements with the commissioner of agriculture to verify licensing, inspection, and compliance information related to hemp processors (in addition to hemp growers as permitted under current law).

84 **Identification card for homeless youth.**

Adds subd. 3b to § 171.07. Authorizes a homeless youth to obtain a Minnesota identification card without paying transaction or filing fees. Sets documentation requirements that apply instead of administrative rules requiring proof of identity, Minnesota residency, and lawful presence in the United States.

This section is effective the day following final enactment for identification card issuances starting January 1, 2022.

85 **Wrongfully obtaining assistance.**

Amends § 256.98, subd. 1. In a subdivision making it a crime to wrongfully obtain certain public assistance, changes a term used related to WIC and makes a technical change.

86 **Lead risk assessments.**

Amends § 256B.0625, subd. 52. Updates a cross-reference to conform with a paragraph relettering in section 144.9504, subdivision 2.

87 **Asbestos-related work.**

Amends § 326.71, subd. 4. Amends a definition of asbestos-related work for sections governing asbestos abatement, to remove an exception to the asbestos abatement requirements for work on asbestos-containing floor tiles and sheeting, roofing materials, siding, and ceilings in single family homes and buildings with four or fewer dwelling units.

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88	**Licensing fee.** Amends § 326.75, subd. 1. Increases the licensing fee to perform asbestos-related work from $100 to $105.
89	**Certification fee.** Amends § 326.75, subd. 2. Increases the fee for certification as an asbestos worker or asbestos site supervisor from $50 to $52.50. Establishes in statute a $105 fee for certification as an asbestos inspector, asbestos management planner, or asbestos project designer (current fees are established in Minnesota Rules, chapter 4620, and are $100 per certification), and removes authority for the commissioner to establish these certification fees by rule.
90	**Permit fee.** Amends § 326.75, subd. 3. Increases the project permit fee that must be paid to the commissioner for asbestos-related work from one percent to two percent of the total costs of the asbestos-related work.
91	**Housing with services establishment registration; conversion to assisted living facility license.** Amends Laws 2020, Seventh Special Session chapter 1, article 6, section 12, subd. 4. Corrects a cross-reference in a subdivision governing conversion of housing with services establishments from registration to assisted living facility licensure. This section is effective the day following final enactment.
92	**Additional member to COVID-19 vaccine allocation advisory group.** Requires the commissioner of health to appoint an expert on vaccine disinformation to the state COVID-19 Vaccine Allocation Advisory Group no later than an unspecified date. This section is effective the day following final enactment.
93	**Federal Schedule I exemption application for the medical use of cannabis.** By September 1, 2021, requires the commissioner of health to apply to the Drug Enforcement Administration's Office of Diversion Control for an exception to federal controlled substances rules, and request formal acknowledgment that the listing of marijuana, marijuana extract, and tetrahydrocannabinols as controlled substances in federal Schedule I does not apply to the use of medical cannabis under the medical cannabis program.

Section	Description - Article 3: Health Department

94 **Recommendations; expanded access to data from all-payer claims database.**

Requires the commissioner of health to develop recommendations to expand access to data in the all-payer claims database to additional outside entities for public health or research purposes, and specifies what the commissioner must address in the recommendations. Requires the recommendations to be submitted by December 15, 2021, to the chairs and ranking minority members of certain legislative committees.

95 **Skin lightening products public awareness and education grant program.**

Requires the commissioner of health to establish a skin lightening products public awareness and education grant program, specifies organizations eligible for and prioritized for grants, and specifies how grant funds must be used.

Subd. 1. Establishment; purpose. Requires the commissioner of health to develop a grant program to increase public awareness and education on the dangers of using skin lightening creams and products that contain mercury.

Subd. 2. Grants authorized. Directs the commissioner to award grants using a request for proposal process to community-based, nonprofit organizations that focus on public health outreach to Black, Indigenous, and people of color communities on issues of chemical exposure from skin lightening products. Requires the commissioner to prioritize organizations that have historically served ethnic communities on this issue for the past three years.

Subd. 3. Grant allocation. Requires grant recipients to use grant funds for public awareness and education activities on the listed topics. Lists information a grant application must include.

96 **Trauma-informed gun violence reduction; pilot program.**

Requires the commissioner of health to establish a gun violence reduction pilot program, requires the commissioner to develop program protocols and guidelines, and requires the commissioner to submit a progress report to certain members of the legislature.

Subd. 1. Pilot program. Directs the commissioner of health to establish a pilot program to reduce trauma resulting from gun violence and to address the root causes of gun violence, by making the following resources available to health, law enforcement, and advocacy professionals likely to encounter individuals affected by or involved in gun violence: training, skills development, investments in community-based organizations to provide high-quality services to individuals in need, replication and expansion of effective gun violence prevention initiatives, and education campaigns and outreach materials.

Section	Description - Article 3: Health Department

Subd. 2. Program guidelines and protocols. Requires the commissioner, with advice from an advisory panel, to develop protocols and program guidelines for resources and training used by professionals likely to encounter individuals affected by or involved in gun violence. Specifies what the materials must address and what the protocols must include. Allows the commissioner to contract with community-based organizations to perform activities required by this section.

Subd. 3. Report. By November 15, 2021, requires the commissioner to 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.

97 **Revisor instruction.**

Directs the revisor of statutes to modify the headnote for section 62J.63.

98 **Repealer.**

Repeals the following:

- section 62J.63, subd. 3 (requiring the commissioner of health to annually report to the legislature on the operations and impact of the Center for Health Care Purchasing Improvement; other sections in this article eliminate this center from statutes);
- section 144.0721, subd. 1 (an obsolete subdivision on assessing appropriateness and quality of care and services to private paying residents in nursing homes and certified boarding care homes);
- section 144.0722 (a section governing resident reimbursement classifications for residents of nursing homes and boarding care homes);
- section 144.0724, subd. 10 (a subdivision specifying the statute under which reconsideration requests for case mix classifications are determined); and
- section 144.693 (a section requiring reports from insurers providing health professional liability insurance to the commissioner of health on closed or filed malpractice claims, and requiring annual reports from the commissioner to the legislature on malpractice claims).

Article 4: Health-Related Licensing Boards

This article contains one section amending a subdivision authorizing individuals to provide certain care or assistance to animals without being licensed by the Board of Veterinary Medicine, to allow emergency medical personnel certified by the Emergency Medical Services

Regulatory Board to provide emergency medical care to a police dog wounded in the line of duty, without being licensed by the Board of Veterinary Medicine.

Article 5: Prescription Drugs

This article contains provisions related to prescription drug costs, health carrier and pharmacy benefit manager requirements related to prescription drugs, drug temperature monitoring, and the drug repository program.

Section	Description - Article 5: Prescription Drugs
1	**Definitions.** Adds § 62J.841. Defines the following terms: Consumer Price Index, generic or off-patent drug, manufacturer, prescription drug, wholesale acquisition cost, and wholesale distributor.
2	**Excessive price increases prohibited.** Adds § 62J.842. **Subd. 1. Prohibition.** Prohibits a manufacturer from imposing, or causing 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 consumers in the state. **Subd. 2. Excessive price increase.** Provides that a price increase is excessive when: 4) the price increase, adjusted by the CPI, exceeds: (i) 15 percent of the WAC over the immediately preceding calendar year; or (ii) 40 percent of the WAC over the three immediately preceding calendar years; and 5) the price increase, adjusted by the CPI, exceeds $30 for a 30-day supply, or course of treatment lasting less than 30 days. **Subd. 3. Exemption.** States that 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 increase is directly attributable to additional costs imposed by the manufacturer.
3	**Registered agent and office within the state.** Adds § 62J.843. Requires manufacturers of generic or off-patent drugs made available in the state to maintain a registered agent and office within the state.
4	**Enforcement.** Adds § 62J.844.

Section Description - Article 5: Prescription Drugs

Subd. 1. Notification. Requires 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, to notify the manufacturer of the drug, the attorney general, and the Board of Pharmacy of any price increase of a generic or off-patent drug that violates section 62J.842.

Subd. 2. Submission of drug cost statement and other information by manufacturer; investigation by attorney general. (a) Requires the manufacturer, within 45 days of receiving notice under subdivision 1, to submit a drug cost statement to the attorney general. Requires the statement to:

1) itemize the cost components related to drug production;
2) identify the circumstances and timing of any increase in materials or manufacturing costs that caused any price increase, in the preceding calendar year or preceding three calendar years as applicable; and
3) provide any other information the manufacturer believes to be relevant.

(b) Allows the attorney general to investigate whether a violation has occurred, is occurring, or is about to occur, in accordance with section 8.31, subdivision 2 (general investigative powers of the attorney general).

Subd. 3. Petition to court. (a) Allows a court, on petition of the attorney general, to issue an order:

1) compelling the manufacturer to provide the drug cost statement, and answer interrogatories, produce records or documents, or be examined under oath, as required by the attorney general;
2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including restoring drug prices to levels that comply with section 62J.842;
3) requiring the manufacturer to account for all revenues resulting from a violation of section 62J.842;
4) requiring the manufacturer to repay all consumers, including third-party payers, any money acquired as a result of a price increase that violates section 62J.842;
5) 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 to reduce consumer drug costs, if the manufacturer is unable to determine the individual transactions necessary to make repayments under clause (4);
6) imposing a civil penalty of up to $10,000 per day for each violation of section 62J.842;

Section	Description - Article 5: Prescription Drugs

7) providing for the recovery of costs and disbursements incurred by the attorney general in bringing an action; and
8) providing any other appropriate relief, including any other equitable relief as determined by the court.

(b) Provides that for purposes of paragraph (a), clause (6), requires every individual transaction in violation of section 62J.842 to be considered a separate violation.

Subd. 4. Private right of action. States that any action brought by a person injured by a violation of this section is for the benefit of the public.

5 **Prohibition on withdrawal of generic or off-patent drugs for sale.**

Adds § 62J.845.

Subd. 1. Prohibition. Prohibits a manufacturer of a generic or off-patent drug from withdrawing that drug from sale or distribution in the state for purposes of avoiding the prohibition on excessive price increases.

Subd. 2. Notice to board and attorney general. Requires any manufacturer that intends to withdraw a generic or off-patent drug from sale or distribution in the state to provide 180 days' written notice of withdrawal to the Board of Pharmacy and the attorney general.

Subd. 3. Financial penalty. Requires the attorney general to assess a $500,000 penalty on any manufacturer that it determines has failed to comply with the requirements of this section.

6 **Severability.**

Adds § 62J.846. Provides that the provisions of sections 62J.841 to 62J.845 are severable.

7 **Prescription drug benefits.**

Amends § 62Q.81, by adding subd. 6.

(a) Requires that 25 percent of the individual health plans offered by an insurer apply a predeductible flat-dollar amount co-pay structure for prescription drugs.

(b) Requires that 25 percent of the small group health plans offered by an insurer apply a predeductible flat-dollar co-pay structure for prescription drugs.

(c) Limits the highest co-pay under this subdivision to 1/12 of the plan's out-of-pocket maximum.

Section	Description - Article 5: Prescription Drugs

(d) Requires the co-pay structure for prescription drugs under this subdivision to be graduated and proportionate.

(e) Requires individual and small group health plans offered under this subdivision to be clearly named, marketed in the same way as other health plans, and offered for purchase to any individual or small group.

(f) Clarifies that this subdivision does not apply to catastrophic plans, grandfathered plans, large group health plans, health savings accounts (HSA), qualified high deductible health benefit plans, limited health benefit plans, or short-term limited-duration health insurance policies.

(g) Requires health plans to meet the requirements of 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.

8 **Prescription drug benefit transparency and management.**

Adds § 62Q.83.

Subd. 1. Definitions. Defines the following terms: drug, enrollee contract term, formulary, health plan company, pharmacy benefits management, and prescription. “Enrollee contract term” is defined as a 12-month term for health plan company products and a calendar quarter for managed care and county-based purchasing plans under MA and MinnesotaCare.

Subd. 2. Prescription drug benefit disclosure. (a) Requires a health plan company that provides drug coverage and uses a formulary to 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) Requires formularies to be organized and disclosed consistent with the most recent version of the United States Pharmacopeia’s Model Guidelines.

(c) Requires the specific enrollee benefit terms, including cost-sharing and out-of-pocket costs, to be identified for each item or category of items on the formulary.

Subd. 3. Formulary changes. (a) Allows a health plan company, at any time during a contract term, to expand the formulary, reduce copayments or coinsurance, or move a drug to a lower cost benefit category.

(b) Allows a health plan company to remove a brand name drug from the formulary or place the drug in a higher cost benefit category only if a generic or

Section	Description - Article 5: Prescription Drugs

multisource drug rated as therapeutically equivalent, or a biologic drug rated as interchangeable, that is at a lower cost to the enrollee, is added, with at least 60 days' notice.

(c) Allows a health plan company to change utilization review requirements or move drugs to a higher cost benefit category, that increases enrollee costs during a contract term, only with 60 days' notice, and provides that the changes do not apply to enrollees taking the drugs for the duration of the contract term.

(d) Allows a health plan company to remove drugs from its formulary that have been deemed unsafe by the Food and Drug Administration (FDA), been withdrawn by the FDA or manufacturer, or when an independent source of research, guidelines, or standards has issued drug-specific warnings or recommended changes in drug usage.

9 **Alternative biological products.**

Adds § 62W.0751.

Subd. 1. Definitions. Defines the following terms: biological product, biosimilar or biosimilar product, interchangeable biological product, and reference biological product.

Subd. 2. Pharmacy and provider choice related to dispensing reference biological products, interchangeable biological products, or biosimilar products. (a) Prohibits a PBM or health carrier from requiring or demonstrating a preference for a pharmacy or health care provider to prescribe or dispense a single biological product for which there is a U.S. Food and Drug Administration (FDA) approved biosimilar or interchangeable biological product, except as provided in paragraph (b).

(b) If a PBM or health carrier elects coverage of a product listed in paragraph (a), requires the PBM or health carrier to also elect equivalent coverage for at least three reference, biosimilar, or interchangeable biological products, or the total number of FDA approved products relative to the reference product if less than three, for which the wholesale acquisition cost (WAC) is less than the WAC of the product listed in paragraph (a).

(c) Prohibits a PBM or health carrier from imposing limits on access to a product required to be covered in paragraph (b) that are more restrictive than the limits imposed on a product listed in paragraph (a) or that have the effect of giving preferred status to the product listed in paragraph (a).

(d) Provides that the section does not apply to MA, MinnesotaCare, or SEGIP coverage.

Section	Description - Article 5: Prescription Drugs

Provides a January 1, 2022, effective date.

10 **Gag clause prohibition.**

Amends § 62W.11. Provides that a PBM or health carrier must not prohibit a pharmacist or pharmacy from discussing with patients the pharmacy's acquisition cost for a prescription drug and the amount the pharmacy is being reimbursed by the PBM or health carrier for the drug.

Also provides that a PBM must not prohibit a pharmacist or pharmacy from discussing with the health carrier the amount the pharmacy is being paid or reimbursed for a prescription drug by the PBM or the pharmacy's acquisition cost for a drug.

11 **Point of sale.**

Amends § 62W.12. Prohibits a PBM or health carrier from requiring an enrollee to pay at the point of sale of a prescription drug an amount greater than the net price of the prescription drug. Defines "net price" as the PBM's or health carrier's cost for the drug, after any rebates or discounts received or accrued directly or indirectly. Provides an effective date of January 1, 2022.

12 **Biosimilar product.**

Amends § 151.01, by adding subd. 43. Defines "biosimilar" or "interchangeable biological product" as a biological product that the FDA has licensed and determined to be biosimilar.

Provides a January 1, 2022, effective date.

13 **Reference biological product.**

Amends § 151.01, by adding subd. 44. Defines "reference biological product" as the single biological product for which the FDA has approved an initial biological product license application, against which other biological products are evaluated for licensure as biosimilar or interchangeable. Provides a January 1, 2022, effective date.

14 **Forms of disciplinary action.**

Amends § 151.071, subd. 1. Allows the Board of Pharmacy to impose a civil penalty not exceeding $25,000 for each separate violation of section 62J.842.

15 **Grounds for disciplinary action.**

Amends § 151.071, subd. 2. Provides that a violation of section 62J.842 or section 62J.845 by a manufacturer is grounds for the Board of Pharmacy to take disciplinary action.

Section	Description - Article 5: Prescription Drugs
16	**Delivery through common carrier; compliance with temperature requirements.** Adds § 151.335. Requires mail order or specialty pharmacies that use the U.S Postal Service or other common carrier to deliver a drug to a patient to ensure that the drug is delivered in compliance with manufacturer temperature requirements. States that the methods used to ensure compliance must include, but are not limited to, enclosing in each medication package a method recognized by the U.S. Pharmacopeia that allows the patient to easily detect improper storage or temperature violations.
17	**Definitions.** Amends § 151.555, subd. 1. Includes over-the-counter medications in the definition of drugs that may be donated to the drug repository program. Provides an immediate effective date.
18	**Standards and procedures for inspecting and storing donated prescription drugs and supplies.** Amends § 151.555, subd. 7. The amendment to paragraph (b) eliminates the requirement that donated drugs and supplies that are not inspected immediately upon receipt be quarantined separately from dispensing stock until inspection. The amendment to paragraph (f) reduces from five to two years the time period during which a repository must maintain records of drugs and supplies that are destroyed because they are not dispensed, subject to recall, or not suitable for donation. Provides an immediate effective date.
19	**Forms and record-keeping requirements.** Amends § 151.555, subd. 11. Reduces from five to two years the time period during which a repository must maintain all records. Provides an immediate effective date.
20	**Cooperation.** Amends § 151.555, by adding subd. 14. Allows the central repository, with the approval of the Board of Pharmacy, to enter into an agreement with another state that has a drug repository or drug donation program that meets specified standards, to permit the central repository to offer inventory to another state program, and to accept inventory from another state program. Provides an immediate effective date.
21	**Service delivery.** Amends § 256B.69, subd. 6. Requires managed care plans and county-based purchasing plans under Medical Assistance to comply with § 62Q.83.
22	**Study of pharmacy and provider choice of biological products.** Requires the commissioner of health, within the limits of existing resources, to analyze the effect of section 62W.0751 on the net price for different payors of

Section	Description - Article 5: Prescription Drugs
	biological products, interchangeable biological products, and biosimilar products. Requires the commissioner to report to the legislature by December 15, 2023.

Article 6: Health Insurance

This article makes changes to health insurance statutes. These changes include modifying provisions related to the Affordable Care Act in state statute and removing references to the Affordable Care Act; establishing requirements for timely provider credentialing; prohibiting lifetime and annual limits on screenings and urinalysis tests for opioids; and establishing requirements for coverage of contraceptives and contraceptive services.

Section	Description - Article 6: Health Insurance
1	**Required provisions.** Amends § 62A.04, subd. 2. Amends a subdivision specifying required provisions for health insurance policies, to delete a reference to qualified health plans and instead refer to individual and small group health plans, and to replace a reference to the ACA with a reference to section 62A.65, subd. 2a that governs a grace period for nonpayment of premiums. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.
2	**Prohibition on waiting periods that exceed 90 days.** Adds subd. 5 to § 62A.10. Prohibits a health carrier offering a group health plan from having an individual who is eligible to enroll in the plan wait to enroll for longer than 90 days. Makes an exception for employees for whom the employer takes time to determine the employee's eligibility, prohibits a cumulative hours of service requirement from exceeding 1,200 hours, allows an orientation period of one month or less to be added to the 90 days, and allows an employer to require a rehired employee to meet the employer's eligibility criteria and waiting period if doing so is reasonable. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.
3	**Applicability.** Amends § 62A.65, subd. 1. Removes an unnecessary cross-reference. Requires a health carrier to offer individual health plans on a guaranteed issue basis and at a premium rate that is not based on the health status of the individual.

Section	Description - Article 6: Health Insurance

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

4 **Grace period for nonpayment of premium.**

Adds subd. 2a to § 62A.65. Allows an individual health plan to be canceled for nonpayment of premiums but requires a health carrier to provide a 3-month grace period. Allows an enrollee to stop a cancellation by paying all outstanding premiums before the end of the grace period.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

5 **Co-payments.**

Amends § 62D.095, subd. 2. Removes a reference to the ACA and instead requires any co-payments and coinsurance imposed in a health maintenance contract to be consistent with state and federal law.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

6 **Deductibles.**

Amends § 62D.095, subd. 3. Removes a reference to the ACA and instead requires any deductibles imposed in a health maintenance contract to be consistent with state and federal law.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

7 **Annual out-of-pocket maximums.**

Amends § 62D.095, subd. 4. Removes a reference to the ACA and instead requires any annual out-of-pocket maximums imposed in a health maintenance contract to be consistent with section 62Q.677, subd. 6a.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

8 **Exceptions.**

Amends § 62D.095, subd. 5. Removes language prohibiting imposition of co-payments and deductibles on preventive health care services consistent with the ACA, and instead prohibits imposition of co-payments and deductibles on preventive items and services as defined in other state law.

Section **Description - Article 6: Health Insurance**

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

9 **Dependent child to the limiting age.**

Amends § 62Q.01, subd. 2a. Removes a reference to the ACA in a subdivision prohibiting a health plan company from denying health plan eligibility for a dependent child under age 26.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

10 **Requirements for timely provider credentialing.**

Adds § 62Q.097. Establishes requirements governing the process of health care provider credentialing by health plan companies.

Subd. 1. Definitions. Defines terms for this section: clean application for provider credentialing or clean application; and provider credentialing.

Subd. 2. Time limit for credentialing determination. Requires a health plan company that receives an application for provider credentialing to do the following. If the application is a clean application and if the provider so requests, the health plan company must notify the provider that the application is clean and specify when the health plan company will make a determination on the application. If the application is not a clean application, the health plan company must notify the provider of the application's deficiencies within 3 business days after a determination that the application is not clean. A health plan company must make a determination on a clean application within 45 days after receipt and, upon notice to the provider, clinic, or facility, may take 30 additional days to investigate quality or safety concerns.

This section applies to applications for provider credentialing submitted on or after January 1, 2022.

11 **Preventive items and services.**

Amends § 62Q.46.

Subd. 1. Coverage for preventive items and services. Amends a definition for preventive items and services by removing a reference to the definition of that term in the ACA and instead adding a reference to subdivision 1a.

Subd. 1a. Preventive items and services. Requires the commissioner of commerce to provide health plan companies with information on which items and services must be categorized as preventive.

Section **Description - Article 6: Health Insurance**

Subd. 3. Additional services not prohibited. Removes references to the ACA and instead refers to preventive items and services categorized as preventive under subdivision 1a.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

12 **Screening and testing for opioids.**

Adds § 62Q.472. Prohibits a health plan company from placing lifetime or annual limits on screenings and urinalysis testing for opioids for enrollees in SUD treatment programs, when ordered by a health care provider and performed by an accredited clinical laboratory. Allows a health plan company to perform medical necessity review for more than 24 screenings or urinalysis tests per 12 months. Specifies that this section does not apply to managed care plans and county-based purchasing plans covering MA or MinnesotaCare enrollees.

This section is effective January 1, 2022, and applies to health plans offered, issued, or renewed on or after that date.

13 **Coverage of contraceptives and contraceptive services.**

Adds § 62Q.521. Establishes requirements for coverage of contraceptives and contraceptive services.

Subd. 1. Definitions. Defines terms for this section: closely held for-profit entity, contraceptive, contraceptive service, eligible organization, medical necessity, religious employer, and therapeutic equivalent version.

Subd. 2. Required coverage; cost sharing prohibited. Paragraph (a) requires a health plan to cover prescription contraceptives and contraceptive services.

Paragraph (b) prohibits health plan companies from imposing cost-sharing on contraceptives or contraceptive services.

Paragraph (c) requires high-deductible health plans with a health savings account to include cost-sharing for contraceptives and contraceptive services at the minimum amount necessary for the enrollee to make tax-exempt contributions and withdrawals from the health savings account.

Paragraph (d) prohibits a health plan company from imposing referral requirements, restrictions, or delays for contraceptives or contraceptive services.

Section Description - Article 6: Health Insurance

Paragraph (e) requires a health plan company to include at least one type of each FDA-approved contraceptive in its formulary. Clarifies that all therapeutic equivalent versions do not need to be included in the formulary.

Paragraph (f) requires health plan companies to list the contraceptives and contraceptive services that are covered without cost-sharing in an easily accessible manner. Requires the list to be promptly updated to reflect changes.

Paragraph (g) requires a health plan company to provide coverage without cost-sharing if an enrollee's health care provider recommends a particular contraceptive or contraceptive service for the enrollee based on medical necessity.

Subd. 3. Religious employers; exempt. Paragraph (a) allows a religious employer to not cover contraceptives or contraceptive services if the employer has religious objections. Requires a religious employer to notify employees as part of the hiring process and all employees at least 30 days before enrollment in the health plan or the effective date of the health plan, whichever is first.

Paragraph (b) provides that if the religious employer covers some contraceptives or contraceptive services, the notice in para. (a) must include a list of what the employer does not cover.

Subd. 4. Accommodation for eligible organizations. Paragraph (a) allows an eligible organization to not cover contraceptives or contraceptive services if the eligible organization notifies the health plan company that it has a religious objection to coverage for all or some contraceptives or contraceptive services.

Paragraph (b) requires the notice from an eligible organization to include certain information.

Paragraph (c) requires an eligible organization to provide this notice to prospective employees as part of the hiring process and to all employees at least 30 days before enrollment in the health plan or at least 30 days before the effective date of the health plan, whichever is first.

Paragraph (d) requires a health plan company that receives notice from an eligible organization to either: (1) exclude coverage for some or all contraceptives or contraceptive services and provide separate payment for any contraceptive or service required to be covered under subdivision 2; or (2) arrange for another entity to provide payments for contraceptive services for plan participants and beneficiaries without imposing cost-sharing, premiums, or other charges on the eligible organization, health plan, participant, or enrollee.

Section **Description - Article 6: Health Insurance**

Paragraph (e) prohibits a health plan company from imposing cost-sharing requirements, premiums, or other charges for contraceptives or contraceptive services to the eligible organization, health plan, or enrollee.

Paragraph (f) requires a health plan company to provide the commissioner of commerce with the number of eligible organization accommodations granted under this subdivision each year.

This section is effective January 1, 2022, and applies to coverage offered, sold, issued, or renewed on or after that date.

14 **Coverage for prescription contraceptives; supply requirements.**

Adds § 62Q.522. Requires health plans to cover a 12-month supply for a prescription contraceptive, with certain exceptions.

Subd. 1. Scope of coverage. Requires health plans that provide prescription coverage to comply with this section, not including religious employers.

Subd. 2. Definition. Defines prescription contraceptive as a drug or device that requires a prescription and is approved by the FDA to prevent pregnancy. States that emergency contraceptives are not prescription contraceptives.

Subd. 3. Required coverage. Requires a health plan to cover a 12-month supply for a prescription contraceptive, and requires the prescribing provider to determine the appropriate number of months to prescribe the contraceptive, up to 12 months.

This section is effective January 1, 2022, and applies to coverage offered, sold, issued, or renewed on or after that date.

15 **Out-of-pocket annual maximum.**

Adds subd. 6a to § 62Q.677. By October of each year, requires the commissioner of commerce to determine the maximum annual out-of-pocket limits that apply to individual and small group health plans.

This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

16 **Essential health benefit package requirements.**

Amends § 62Q.81.

Section Description - Article 6: Health Insurance

Subd. 1. Essential health benefits package. Removes cross-references to the ACA and inserts appropriate references to subdivisions in this section governing essential health benefits and metal levels for health plans.

Subd. 2. Cost-sharing; coverage for enrollees under the age of 21. Paragraph (a) specifies what is and is not included in cost-sharing.

Paragraph (b) limits cost-sharing per year for individual health plans to the amount allowed under the Internal Revenue Code plus a premium adjustment percentage.

Paragraph (c) limits cost-sharing per year for small group health plans to twice the amount allowed for individual health plans.

In paragraph (d) a reference to the ACA is stricken and a cross-reference is modified.

Subd. 3. Levels of coverage; alternative compliance for catastrophic plans. Requires bronze, silver, gold, and platinum level health plans offered by health carriers to be actuarially equivalent to a certain percentage of the actuarial value of the benefits provided. Specifies circumstances under which catastrophic health plans may be sold and what those plans must include. Removes references to the ACA.

Subd. 4. Essential health benefits; definition. Paragraph (a) removes a reference to the ACA to define essential health benefits and instead defines that term as the services listed in that paragraph plus additional benefits included in a typical employer plan.

Paragraph (b) provides out-of-network providers of emergency services cannot impose more restrictive prior authorization requirements or coverage limitations than those required by in-network providers. Requires cost-sharing to be equivalent between in-network and out-of-network providers for these services.

Paragraph (c) requires the scope of essential health benefits to be equal to the scope of benefits provided under a typical employer plan.

Paragraph (d) lists requirements for essential health benefits.

Subd. 5. Exception. Removes a reference to the ACA and instead provides that this section does not apply to dental plans that are limited in scope and provide pediatric dental benefits.

Section	Description - Article 6: Health Insurance
	This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.
17	**Laboratory and x-ray services.** Amends § 256B.0625, subd. 10. Specifies that medical assistance covers screenings and urinalysis tests for opioids without lifetime or annual limits. This section is effective January 1, 2022.
18	**Drugs.** Amends § 256B.0625, subd. 13. Requires medical assistance coverage for a prescription contraceptive to provide a 12-month supply and requires the prescribing provider to determine the appropriate number of months to prescribe the prescription contraceptive, up to 12 months. Defines prescription contraceptive and specifies that prescription contraceptive does not include an emergency contraceptive. This section applies to MA and MinnesotaCare coverage effective January 1, 2022.
19	**Commissioner of commerce; determination of preventive items and services.** Directs the commissioner of commerce to determine the items and services that are preventive, and lists what must be included as preventive items and services.

Article 7: Telehealth

This article expands coverage of telehealth services and requires coverage of telemonitoring, for private sector insurance coverage and health care programs and services administered by the Department of Human Services.

Section	Description - Article 7: Telehealth
1	**Coverage of services provided through telehealth.** Adds § 62A.673. Establishes requirements for the coverage of telehealth by health carriers. This section incorporates language from telemedicine requirements in sections 62A.67 to 62A.672 (these sections are repealed in the bill) and provisions from Laws 2020, chapter 74, as well as new language. **Subd. 1. Citation.** States that this section may be cited as the "Minnesota Telehealth Act." **Subd. 2. Definitions.** Defines the following terms: distant site, health care provider, health carrier, health plan, originating site, store-and-forward transfer,

Section **Description - Article 7: Telehealth**

and telehealth. These definitions are modifications of those in current law in § 62A.671. Major differences include:

- The definition of "health care provider" includes mental health practitioners (one of the groups added temporarily in chapter 74) and also treatment coordinators, alcohol and drug counselors, and recovery peers.
- The definition of "telehealth" is a revision of the definition of "telemedicine" in current law. The revised definition specifically includes "audio-only communication between a health care provider and a patient" if this is a scheduled appointment and the standard of care can be met; this is not explicit in current law.
- Provides a definition of "telemonitoring services;" this term is not defined in current law.

Subd. 3. Coverage of telehealth. (a) Requires health plans to cover benefits delivered through telehealth in the same manner as any other benefits, and to comply with this section. (Similar to language in § 62A.672.)

(b) Prohibits coverage of telehealth services from being limited on the basis of geography, location, or distance for travel. (New provision.)

(c) Prohibits a health carrier from creating a separate provider network or providing incentives for enrollees to use a separate provider network to deliver telehealth services, if this network does not include network providers who provide in-person care for the same service. (New provision.)

(d) Allows a health carrier to include cost-sharing for a service provided through telehealth, if this cost-sharing is not in addition to, and does not exceed, cost-sharing for the same service provided in-person. (Similar to language in § 62A.67.)

(e) States that nothing in this section shall be construed to: (1) require a health carrier to provide coverage for services that are not medically necessary or not covered under the enrollee's health plan; or (2) prohibit a health carrier from:

(i) establishing safety and efficacy criteria for a particular telehealth service for which other providers are not already reimbursed under telehealth;

(ii) establishing reasonable medical management techniques; or

(iii) requiring documentation or billing practices designed to prevent fraudulent claims.

Section **Description - Article 7: Telehealth**

(Item (ii) and the reference in clause (1) to services covered under a health plan are new; the other provisions in this paragraph are similar to language in § 62A.672.)

(f) States that nothing in this section shall be construed to require the use of telehealth when a provider determines this is not appropriate or the enrollee chooses not to receive a health care service through telehealth. (New provision.)

Subd. 4. Parity between telehealth and in-person services. (a) Prohibits a health carrier from restricting or denying coverage of a covered health care service solely: (1) because the service is not provided in-person; or (2) based on the communication technology or application used to deliver the service through telehealth, provided the technology or application complies with this section and is appropriate for the particular service. (Clause (1) is similar to language in § 62A.672; clause (2) is new.)

(b) Allows prior authorization to be used for a telehealth service only if it is required when the same service is delivered in-person. (New provision.)

(c) Allows a health carrier to require utilization review for a service delivered through telehealth so long as it is conducted in the same manner and uses the same clinical review criteria as utilization review for the same service delivered in-person. (New provision.)

Subd. 5. Reimbursement for services delivered through telehealth. (a) Requires health carriers to reimburse providers for telehealth services on the same basis and at the same rate as would apply had the service been delivered in-person. (Similar to language in § 62A.672.)

(b) Prohibits a health carrier from denying or limiting reimbursement solely because the service was delivered though telehealth rather than in-person. (Similar to temporary language in chapter 74.)

(c) Prohibits a health carrier from denying or limiting reimbursement based solely on the technology and equipment used by the health care provider to deliver the service through telehealth, as long as the technology and equipment meets the requirements of this section and is appropriate for the particular service. (Similar to temporary language in chapter 74.)

Subd. 6. Telehealth equipment. (a) Prohibits a health carrier from requiring a provider to use specific telecommunications technology and equipment as a condition of coverage, as long as this technology and equipment complies with current industry interoperable standards and with federal Health Insurance

Section **Description - Article 7: Telehealth**

Portability and Accountability Act (HIPAA) standards and regulations, unless authorized under this section.

(b) Requires a health carrier to cover services delivered through telehealth by audio-only telephone communication, if this communication is a result of a scheduled appointment and the standard of care for the particular service can be met through audio-only communication. (The provisions in this subdivision are new.)

Subd. 7. Telemonitoring services. Requires a health carrier to provide coverage for telemonitoring services if: (1) the services are medically appropriate for the enrollee; (2) the enrollee is capable of operating the monitoring device or equipment, or has a caregiver willing and able to assist; and (3) the enrollee resides in a setting suitable for telemonitoring and not in a setting with health care staff on site. (The provisions in this subdivision are new.)

2 **Practice of telehealth.**

Amends § 147.033. Modifies telehealth provisions in the physician licensure statute.

Subd. 1. Definition. Changes terminology from "telemedicine" to "telehealth" and modifies definition to be consistent with the definition in § 62A.673.

Subd. 2. Physician-patient relationship. Modifies terminology from "telemedicine" to "telehealth."

Subd. 3. Standards of practice and conduct. Modifies terminology from "telemedicine" to "telehealth."

3 **Prescribing and filing.**

Amends § 151.37, subd. 2. Reorganizes provision relating to examination requirement for licensed practitioners prescribing certain drugs; specifies drugs for which an examination via telehealth meets the requirements.

Makes this section effective the day following final enactment.

4 **Face-to-face.**

Amends § 245G.01, subd. 13. Modifies definition of "face-to-face" in the substance use disorder treatment program licensing chapter, to clarify that services delivered via telehealth should prioritize using combined audio and visual communication.

Makes this section effective January 1, 2022, or upon federal approval, whichever is later.

Section	Description - Article 7: Telehealth
5	**Telehealth.** Amends § 245G.01, subd. 26. Modifies terminology to "telehealth" and definition for "telemedicine" in the substance use disorder treatment program licensing chapter.
6	**General.** Amends § 245G.06, subd. 1. Allows an alcohol and drug counselor to document a client's approval of a treatment plan verbally, in lieu of a signature, if a client is receiving services or an assessment via telehealth.
7	**Assessment via telehealth.** Amends § 254A.19, subd. 5. Adds cross-reference to definition of telehealth. Makes this section effective January 1, 2022, or upon federal approval, whichever is later.
8	**Rate requirements.** Amends § 254B.05, subd. 5. Modifies paragraph (f) to clarify terminology and add cross-reference to definition of telehealth. Makes this section effective January 1, 2022, or upon federal approval, whichever is later.
9	**Mental health case management.** Amends § 256B.0596. Adds telehealth contact, with at least one in-person contact every six months, to provider requirements for mental health case management.
10	**Telehealth services.** Amends § 256B.0625, subd. 3b. Modifies MA coverage of telehealth services, to be consistent with changes made to telemedicine coverage requirements for health carriers that are reflected in § 62A.676. Under current law, MA coverage is generally consistent with § 62A.67 to 62A.672 (these sections are repealed in the bill and modified provisions are included in § 62A.676). The amendment to paragraph (a) eliminates the three visit per enrollee per calendar week limit on the provision of telehealth services and makes conforming changes. The amendment to paragraph (b) allows the commissioner to establish criteria that health care providers must attest to in order to demonstrate the safety or efficacy of a service delivered through telehealth (this is required of the commissioner under current law). Also makes conforming changes. The amendment to paragraph (c) makes conforming changes.

Section **Description - Article 7: Telehealth**

The amendment to paragraph (d) replaces the definition of "telemedicine" with the definition of "telehealth." (This is the same definition as provided in § 62A.673, except that audio-only communication between a provider and patient is not covered if interactive visual and audio communication is specifically required.) The amendment to paragraph (d) also makes conforming changes in terminology.

The amendment to paragraph (e) of current law incorporates the definition of "health care provider" used in § 62A.673 (this includes adding mental health practitioners), but expands the definition to also include other mental health and substance use disorder service providers. The amendment also incorporates the definitions of originating site, distant site, and store-and-forward transfer used in § 62A.673 into the MA statute. "Distant site" and "store-and-forward transfer" had not previously been defined in this section. Community paramedics and community health workers are retained in the MA definition of "health care provider" (these providers are not included in the definition of health care provider used in § 62A.673).

The amendment to paragraph (f) of current law makes a conforming change to the elimination of the three visit per week limit on the provision of telehealth services.

States that the section is effective January 1, 2022, or upon federal approval, whichever is later.

11 **Telemonitoring services.**

Amends § 256B.0625, by adding subd. 3h.

(a) States that MA covers telemonitoring services if the recipient:

1) has been diagnosed with and is receiving services for at least one specified chronic condition;
2) requires monitoring at least five times per week to manage the condition;
3) has had two or more emergency room or inpatient hospital stays within the last 12 months due to the chronic condition, or the recipient's health care provider has identified that telemonitoring would likely prevent admission or readmission to a hospital, emergency room, or nursing facility;
4) is capable of operating the monitoring device or equipment, or has a caregiver willing and able to assist; and
5) resides in a setting suitable for telemonitoring and not in a setting with health care staff on site.

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(b) Provides a definition of "telemonitoring services." The definition specifies the provider types that can assess and monitor the data transmitted by telemonitoring.

12 **Medication therapy management services.**

Amends §256B.0625, subd. 13h.

The amendment to paragraph (b) eliminates the requirement that a pharmacist practice in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process, in order to be eligible for MA reimbursement for medication therapy management services.

The amendment to paragraph (c) eliminates a reference to the commissioner establishing contact requirements between the pharmacist and recipient.

The amendment to paragraph (d) states that medication therapy management services may be provided by telehealth and delivered in a patient's residence. Strikes current law which provides coverage for the service when provided through two-way interactive video if there are no pharmacists practicing within a reasonable geographic distance. Also strikes language limiting reimbursement to situations in which both the pharmacist and patient are located in an ambulatory care setting, and prohibiting services from being transmitted into the patient's residence.

Strikes paragraph (e), which specifies requirements for the delivery of medication therapy management services into a patient's residence through secure interactive video.

13 **Mental health case management.**

Amends § 256B.0625, subd. 20. Allows for medical assistance and MinnesotaCare payment for mental health case management for children provided thought contact by interactive video that meets statutory requirements.

14 **Mental health targeted case management through interactive video.**

Amends § 256B.0625, subd. 20b. Modifies mental health targeted case management interactive video frequency requirements to allow for up to two consecutive interactive video contacts following in-person contact, not to exceed 50% of the required face-to-face contact.

15 **Mental health telehealth.**

Amends § 256B.0625, subd. 46. Clarifies terminology and adds cross-reference to definition of telehealth.

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Makes this section effective January 1, 2022, or upon federal approval, whichever is later.

16 **Definitions.**

Amends § 256B.0911, subd. 1a. Modifies the definition of "long-term care consultation services" by removing language requiring long-term care consultation assessments to be face-to-face.

17 **Assessment and support planning.**

Amends § 256B.0911, subd. 3a. Makes technical and conforming changes. Adds paragraph (q), which requires all long-term care consultation assessments to be face-to-face unless the assessment is a reassessment that meets specified requirements such as:

1) allowing remote reassessments to be conducted by interactive video or telephone for services provided under alternative care, the elderly waiver, the developmental disabilities waiver, the CADI waiver, and the BI waiver;
2) allowing remote assessments to substitute for two consecutive reassessments if followed by a face-to-face reassessment; and
3) allowing a remote assessment if the person being assessed, the person's legal representative, and the lead agency case manager all agree that a remote reassessment is appropriate.

Gives the person being reassessed, or the person's legal representative, the right to refuse a remote reassessment at any time. Requires a certified assessor to suspend a remote reassessment and schedule a face-to-face reassessment if the certified assessor determines that a remote reassessment is inappropriate. Applies all other requirements of a face-to-face reassessment to a remote reassessment.

18 **Long-term care reassessments and community support plan updates.**

Amends § 256B.0911, subd 3f. Makes conforming changes in the section of statutes governing long-term care consultation services.

19 **Preadmission screening of individuals under 65 years of age.**

Amends § 256B.0911, subd. 4d. Makes conforming changes in the section of statutes governing long-term care consultation services. Also specifies criteria for remote assessments. Gives the person being reassessed, or the person's legal representative, the right to refuse a remote assessment at any time.

20 **Targeted case management through interactive video.**

Amends § 256B.0924, subd. 4a. Modifies targeted case management interactive video frequency requirements to allow for up to two consecutive interactive video

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contacts following in-person contact, not to exceed 50% of the required face-to-face contact.

21 **Payment for targeted case management.**

Amends § 256B.0924, subd. 6. Allows for medical assistance and MinnesotaCare payment for targeted management provided thought contact by interactive video that meets statutory requirements.

22 **Medical assistance reimbursement of case management services.**

Amends § 256B.094, subd. 6. Allows for case management face-to-face contacts for clients or children placed more than 60 miles from the county or tribal boundaries to occur via interactive video for up to two consecutive contacts following each in-person contact.

23 **Assessment and reassessment.**

Amends § 256B.49, subd. 14. Removes language requiring assessments to be face-to-face in the section of statutes governing home and community-based service waivers for persons with disabilities.

24 **Submitting application form.**

Amends § 256J.09, subd. 3. Modifies county agency duties related to the information the agency must provide to potential MFIP applicants by requiring the agency to inform a person that the application may be submitted by telephone or through Internet telepresence and the interview may be conducted by telephone. Makes technical and conforming changes.

25 **County agency to provide orientation.**

Amends § 256J.45, subd. 1. Removes the requirement that the MFIP orientation be provided face-to-face.

26 **Nursing facility level of care determination required.**

Amends § 256S.05, subd. 2. Makes a conforming change in the chapter of statutes governing the elderly waiver related to the changes in long-term care consultation assessments.

27 **Study of telehealth.**

(a) Requires the commissioner of human services, in consultation with the commissioners of health and commerce, to study the impact of telehealth payment methodologies and expansion under this act on the coverage and provision of telehealth services in public and private sector health coverage. Requires the study to review specified topics.

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	(b) Requires the commissioner to consult with stakeholders and communities, and allows the commissioner to use data from the all-payer claims database. Requires the commissioner to report to the legislature by February 15, 2023.
28	**Effective date.** Provides that the sections in the article related to medical assistance and DHS substance use disorder treatment are effective January 1, 2022.
29	**Expiration date.** Provides that the sections in the article related to medical assistance and DHS substance use disorder treatment expire July 1, 2023. Exempts the definition of "originating site" from expiration.
30	**Revisor instruction.** Directs the revisor to substitute the term "telehealth" for "telemedicine" in Minnesota Statutes and Minnesota Rules, and to substitute "section 62A.673" whenever references to sections 62A.67, 62A.671, and 62A.672 appear.
31	**Repealer.** Repeals sections 62A.67, 62A.671, and 62A.672 (current law governing coverage of telemedicine services by health carriers).

Article 8: Appropriations

This article appropriates money for fiscal years 2022 and 2023 from the specified funds to the commissioner of human services, the commissioner of health, the health-related licensing boards, the Emergency Medical Services Regulatory Board, the Council on Disability, the ombudsman for mental health and developmental disabilities, and the ombudspersons for families. It also:

- reduces fiscal year 2021 appropriations from the state government special revenue fund to the commissioner of health;
- transfers an appropriation to the commissioner of health from fiscal year 2021 to fiscal year 2022;
- appropriates money in fiscal year 2021 to the commissioner of human services for an MFIP supplemental payment;
- refinances certain fiscal year 2020 emergency child care grants with money from the coronavirus relief federal fund;
- appropriates to the commissioner of health, federal funds made available to the commissioner for vaccine activities;

- replaces expenditures authorized in this article with federal funds from the American Rescue Plan Act if the commissioner of management and budget determines those funds can be used for expenditures authorized in this article; and
- repeals a subdivision requiring the commissioner of management and budget to transfer excess funds from the health care access fund to the general fund each June 30, effective June 30, 2025.