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

Page 1, after line 27, insert:

"Section 1. Minnesota Statutes 2020, section 256.969, subdivision 2b, is amended to read:

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

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

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

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

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

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

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade

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

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

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

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

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

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

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

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

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

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

rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

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

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

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

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

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

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

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

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

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

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

(6) geographic location.

Sec. 2. Minnesota Statutes 2020, section 256.969, subdivision 9, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(e)~~ (f) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to

exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

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

Page 3, delete section 3

Page 14, after line 32, insert:

"Sec. 8. Minnesota Statutes 2020, section 256B.0625, subdivision 30, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization in accordance with section 1905(b) of the Social Security Act for expenditures made to

organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

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

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

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

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

(i) general social services and administrative costs;

(ii) retail pharmacy;

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

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

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

(ix) contributions and donations;

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

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

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

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

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

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

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

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

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

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

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

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

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the

date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

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

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

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

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

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

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

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

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

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

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

Page 15, delete section 9

Page 23, after line 5, insert:

"Sec. 18. **RESPONSE TO COVID-19 PUBLIC HEALTH EMERGENCY.**

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

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

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

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

Sec. 19. **HEALTH COVERAGE EXPANSION STUDY.**

(a) The commissioner of human services, in consultation with the commissioners of commerce and management and budget and the MNsure Board of Directors, shall study the costs and requirements for establishing a public option that would:

(1) provide coverage options for individuals who may otherwise seek coverage in the individual and small group health insurance market with covered benefits and a provider network similar to MinnesotaCare and review and provide actuarial analysis on multiple plan designs;

(2) contract directly with all health care providers willing to participate and accept reimbursement and other contract terms;

(3) use a single third-party administrator or be administered directly by the commissioner of human services;

(4) establish a reimbursement methodology that is demonstrated to adequately reimburse providers serving individuals in medical assistance, MinnesotaCare, and the public option and maximizes federal financial participation;

(5) utilize modernized information technology systems that integrate with existing public health care programs and support households with individuals using public programs, the public option, and qualified health plans;

(6) charge premiums on a sliding scale using the required contribution limits in Code of Federal Regulations, title 26, section 36B(c)(2)(C)(i)(II), and state-funded tax credits for persons whose costs exceed the federal contribution limits for both individual and family coverage; and

(7) be available in every Minnesota county.

(b) The commissioner of human services shall present a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and health insurance by January 15, 2022. The report must comply with Minnesota Statutes, sections 3.195 and 3.197.

Sec. 20. **RATE-SETTING METHODOLOGY FOR OUTPATIENT RATES.**

The commissioner of human services shall conduct a comprehensive analysis and issue a report regarding the current rate-setting methodology for all outpatient services in medical assistance and MinnesotaCare. The report shall include an assessment of the adequacy of rates and alternative rate methodologies, consistent with the intent and direction of the

Centers for Medicare and Medicaid Services. In addition, the report must examine rate structures for a public option. In developing the report, the commissioner shall consult with stakeholders and with outside experts in Medicaid financing. The commissioner shall provide a report on the analysis to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and health insurance by January 15, 2023. The report must comply with Minnesota Statutes, sections 3.195 and 3.197."

Page 23, line 11, delete "chapter 245C" and insert "section 245C.031"

Page 23, line 15, delete "must" and insert "may"

Page 24, line 4, strike "check" and insert "study"

Page 24, line 8, strike "checks" and insert "studies"

Page 24, line 9, strike "check" and insert "study"

Page 24, line 14, strike everything after the period

Page 24, strike line 15

Page 24, line 18, strike "check" and insert "study"

Page 28, after line 33, insert:

"Sec. 4. Minnesota Statutes 2020, section 245C.02, subdivision 4a, is amended to read:

Subd. 4a. **Authorized fingerprint collection vendor.** "Authorized fingerprint collection vendor" means a qualified organization under a written contract with the commissioner to provide services in accordance with section 245C.05, subdivision 5, paragraph (b). The commissioner may retain the services of more than one authorized fingerprint collection vendor.

Sec. 5. Minnesota Statutes 2020, section 245C.02, subdivision 5, is amended to read:

Subd. 5. **Background study.** "Background study" means:

(1) the collection and processing of a background study subject's fingerprints, including the process of obtaining a background study subject's classifiable fingerprints and photograph as required by section 245C.05, subdivision 5, paragraph (b); and

(2) the review of records conducted by the commissioner to determine whether a subject is disqualified from direct contact with persons served by a program and, where specifically

provided in statutes, whether a subject is disqualified from having access to persons served by a program and from working in a children's residential facility or foster residence setting.

Sec. 6. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision to read:

Subd. 5b. **Alternative background study.** "Alternative background study" means:

(1) the collection and processing of a background study subject's fingerprints, including the process of obtaining a background study subject's classifiable fingerprints and photograph as required by section 245C.05, subdivision 5, paragraph (b); and

(2) a review of records conducted by the commissioner pursuant to section 245C.08 in order to forward the background study investigating information to the entity that submitted the alternative background study request under section 245C.031, subdivision 2. The commissioner shall not make any eligibility determinations on background studies conducted under section 245C.031."

Page 29, line 3, delete "5b" and insert "5c"

Page 29, line 4, delete "review" and insert "retrieval"

Page 29, line 5, delete "investigating"

Page 29, line 11, after "program" insert a comma and delete "or" and after "organization" insert ", or agency"

Page 30, after line 17, insert:

"(c) This subdivision applies to the following programs that must be licensed under chapter 245A:

(1) adult foster care;

(2) child foster care;

(3) children's residential facilities;

(4) family child care;

(5) licensed child care centers;

(6) licensed home and community-based services under chapter 245D;

(7) residential mental health programs for adults;

(8) substance use disorder treatment programs under chapter 245G;

(9) withdrawal management programs under chapter 245F;

(10) programs that provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons;

(11) adult day care centers;

(12) family adult day services;

(13) independent living assistance for youth;

(14) detoxification programs;

(15) community residential settings; and

(16) intensive residential treatment services and residential crisis stabilization under chapter 245I."

Page 30, line 22, delete "1, 4, 6a, 9, and 9a" and insert "1, paragraph (c), clauses (2) to (5), and 6a"

Page 30, delete subdivision 3a

Page 31, line 11, delete "3b" and insert "3a"

Page 31, after line 26, insert:

"Subd. 3b. **Exception to personal care assistant; requirements.** The personal care assistant for a recipient may be allowed to enroll with a different personal care assistance provider agency upon initiation of a new background study according to this chapter if:

(1) the commissioner determines that a change in enrollment or affiliation of the personal care assistant is needed in order to ensure continuity of services and protect the health and safety of the recipient;

(2) the chosen agency has been continuously enrolled as a personal care assistance provider agency for at least two years;

(3) the recipient chooses to transfer to the personal care assistance provider agency;

(4) the personal care assistant has been continuously enrolled with the former personal care assistance provider agency since the last background study was completed; and

(5) the personal care assistant continues to meet requirements of section 256B.0659, subdivision 11, notwithstanding paragraph (a), clause (3)."

Page 32, line 11, delete "of health" and delete "contract with the commissioner"

Page 32, line 12, delete "of human services to"

Page 32, line 20, delete "section 245C.03, subdivision 1," and insert "subdivision 2"

Page 32, line 24, delete "understudy" and insert "undergoing a study"

Page 33, line 11, delete "and detention facilities" and insert ", juvenile detention facilities, and foster residence settings,"

Page 33, line 13, after "facilities" insert "or settings"

Page 33, line 17, delete everything after "local"

Page 33, line 18, delete "national" and insert "state"

Page 34, line 13, after "older" insert "and lives in the household where nonlicensed child care is provided"

Page 34, strike lines 21 to 24

Page 37, line 22, after "data" insert a period

Page 37, delete line 23

Page 38, line 6, delete "9" and insert "12"

Page 38, delete lines 30 to 32

Page 39, line 1, delete "commissioner of human services."

Page 40, line 4, delete "held" and insert "obtained"

Page 42, line 14, delete "5" and insert "8"

Page 42, line 17, delete "held" and insert "obtained" and after the semicolon, insert "and"

Page 42, line 27, delete the semicolon and insert a period

Page 42, delete lines 28 to 31

Page 42, line 33, delete "investigating information" and insert "records"

Page 43, line 27, before "The" insert "(a)"

Page 43, line 28, after the period, insert "Notwithstanding subdivision 1, paragraph (g), the commissioner shall conduct a background study only based on Minnesota criminal records of:"

Page 43, after line 28, insert:

"(1) each navigator;

(2) each in-person assister; and

(3) each certified application counselor.

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

(c) The commissioner shall review information that the commissioner receives to determine if the study subject has potentially disqualifying offenses. The commissioner shall send a letter to the subject indicating any of the subject's potential disqualifications as well as any relevant records. The commissioner shall send a copy of the letter indicating any of the subject's potential disqualifications to the MNsure board.

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

Page 44, line 10, reinstate the stricken language

Page 44, line 11, reinstate the stricken language and delete the new language

Page 45, after line 17, insert:

"Sec. 16. Minnesota Statutes 2020, section 245C.05, subdivision 2c, is amended to read:

Subd. 2c. **Privacy notice to background study subject.** (a) Prior to initiating each background study, the entity initiating the study must provide the commissioner's privacy notice to the background study subject required under section 13.04, subdivision 2. The notice must be available through the commissioner's electronic NETStudy and NETStudy 2.0 systems and shall include the information in paragraphs (b) and (c).

(b) The background study subject shall be informed that any previous background studies that received a set-aside will be reviewed, and without further contact with the background study subject, the commissioner may notify the agency that initiated the subsequent background study:

(1) that the individual has a disqualification that has been set aside for the program or agency that initiated the study;

(2) the reason for the disqualification; and

(3) that information about the decision to set aside the disqualification will be available to the license holder upon request without the consent of the background study subject.

(c) The background study subject must also be informed that:

(1) the subject's fingerprints collected for purposes of completing the background study under this chapter must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or by the commissioner. The Federal Bureau of Investigation will only retain fingerprints of subjects with a criminal history;

(2) effective upon implementation of NETStudy 2.0, the subject's photographic image will be retained by the commissioner, and if the subject has provided the subject's Social Security number for purposes of the background study, the photographic image will be available to prospective employers and agencies initiating background studies under this chapter to verify the identity of the subject of the background study;

(3) the commissioner's authorized fingerprint collection vendor or vendors shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized fingerprint collection vendor or vendors shall retain no more than the subject's name and the date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities;

(4) the commissioner shall provide the subject notice, as required in section 245C.17, subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

(5) the subject may request in writing a report listing the entities that initiated a background study on the individual as provided in section 245C.17, subdivision 1, paragraph (b);

(6) the subject may request in writing that information used to complete the individual's background study in NETStudy 2.0 be destroyed if the requirements of section 245C.051, paragraph (a), are met; and

(7) notwithstanding clause (6), the commissioner shall destroy:

(i) the subject's photograph after a period of two years when the requirements of section 245C.051, paragraph (c), are met; and

(ii) any data collected on a subject under this chapter after a period of two years following the individual's death as provided in section 245C.051, paragraph (d)."

Page 46, delete lines 10 and 11

Page 46, line 14, delete "Authorized recipient" and insert "Authorization" and delete "the"

Page 46, line 15, delete "recipient of information and records received" and insert "to receive information"

Page 46, delete section 16

Page 46, after line 20, insert:

"Sec. 20. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 1b. **Background study fees.** (a) The commissioner shall recover the cost of background studies. Except as otherwise provided in subdivisions 1c and 1d, the fees collected under this section shall be appropriated to the commissioner for the purpose of conducting background studies under this chapter. Fees under this section are charges under section 16A.1283, paragraph (b), clause (3).

(b) Background study fees may include:

(1) a fee to compensate the commissioner's authorized fingerprint collection vendor or vendors for obtaining and processing a background study subject's classifiable fingerprints and photograph pursuant to subdivision 1c; and

(2) a separate fee under subdivision 1c to complete a review of background-study-related records as authorized under this chapter.

(c) Fees charged under paragraph (b) may be paid in whole or part when authorized by law by a state agency or board; by state court administration; by a service provider, employer, license holder, or other organization that initiates the background study; by the commissioner or other organization with duly appropriated funds; by a background study subject; or by some combination of these sources.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 21. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 1c. **Fingerprint and photograph processing fees.** The commissioner shall enter into a contract with a qualified vendor or vendors to obtain and process a background study subject's classifiable fingerprints and photograph as required by section 245C.05. The commissioner may, at their discretion, directly collect fees and reimburse the commissioner's authorized fingerprint collection vendor for the vendor's services or require the vendor to

collect the fees. The authorized vendor is responsible for reimbursing the vendor's subcontractors at a rate specified in the contract with the commissioner.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 22. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision to read:

Subd. 1d. **Background studies fee schedule.** (a) By March 1 each year, the commissioner shall publish a schedule of fees sufficient to administer and conduct background studies under this chapter. The published schedule of fees shall be effective on July 1 each year.

(b) Fees shall be based on the actual costs of administering and conducting background studies, including payments to external agencies, department indirect cost payments under section 16A.127, processing fees, and costs related to due process.

(c) The commissioner shall publish a notice of fees by posting fee amounts on the department website. The notice shall specify the actual costs that comprise the fees including the categories described in paragraph (b).

(d) The published schedule of fees shall remain in effect from July 1 to June 30 each year.

(e) The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies, alternative background studies, and criminal background checks.

EFFECTIVE DATE. This section is effective July 1, 2021. The commissioner of human services shall publish the initial fee schedule on the Department of Human Services website on July 1, 2021, and the initial fee schedule is effective September 1, 2021."

Page 47, delete section 20

Page 47, line 26, delete "20" and insert "19"

Page 47, line 28, delete "245C.03" and insert "245C.031"

Page 48, delete sections 22 to 24

Page 50, delete lines 4 to 6

Page 50, line 12, delete "3a" and insert "3b"

Page 55, after line 9, insert:

"Sec. 37. Minnesota Statutes 2020, section 245C.32, subdivision 1a, is amended to read:

Subd. 1a. **NETStudy 2.0 system.** (a) The commissioner shall design, develop, and test the NETStudy 2.0 system and implement it no later than September 1, 2015.

(b) The NETStudy 2.0 system developed and implemented by the commissioner shall incorporate and meet all applicable data security standards and policies required by the Federal Bureau of Investigation (FBI), Department of Public Safety, Bureau of Criminal Apprehension, and the Office of MN.IT Services. The system shall meet all required standards for encryption of data at the database level as well as encryption of data that travels electronically among agencies initiating background studies, the commissioner's authorized fingerprint collection vendor or vendors, the commissioner, the Bureau of Criminal Apprehension, and in cases involving national criminal record checks, the FBI.

(c) The data system developed and implemented by the commissioner shall incorporate a system of data security that allows the commissioner to control access to the data field level by the commissioner's employees. The commissioner shall establish that employees have access to the minimum amount of private data on any individual as is necessary to perform their duties under this chapter.

(d) The commissioner shall oversee regular quality and compliance audits of the authorized fingerprint collection vendor or vendors."

Page 55, after line 16, insert:

"Sec. 39. Laws 2020, First Special Session chapter 7, section 1, as amended by Laws 2020, Third Special Session chapter 1, section 3, is amended by adding a subdivision to read:

Subd. 5. **Waivers and modifications; extension for 365 days.** When the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, waiver CV23: modifying background study requirements, issued by the commissioner of human services pursuant to Executive Orders 20-11 and 20-12, including any amendments to the modification issued before the peacetime emergency expires, shall remain in effect for 365 days after the peacetime emergency ends.

EFFECTIVE DATE. This section is effective the day following final enactment or retroactively from the date the peacetime emergency declared by the governor in response to the COVID-19 outbreak ends, whichever is earlier."

Page 56, after line 14, insert:

"Sec. 2. Minnesota Statutes 2020, section 256.01, subdivision 28, is amended to read:

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

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

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

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

Page 68, after line 24, insert:

"Sec. 10. Minnesota Statutes 2020, section 256B.0631, subdivision 1, is amended to read:

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

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

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

(3) subject to a $12 per month maximum for prescription drug co-payments, $3 per brand-name drug prescription ~~and~~, $1 per generic drug prescription, ~~subject to a $12 per month maximum for prescription drug co-payments~~ and $1 per brand-name multisource drug listed in preferred status on the preferred drug list under section 256B.0625, subdivision 13g. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

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

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

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

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

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

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

Page 69, line 9, after "2023" insert ", or upon completion of the Medicaid Management Information System pharmacy module modernization project, whichever is later. The commissioner shall notify the revisor of statutes when the project is completed"

Page 75, line 24, after "supplies" insert", except pressure support ventilators,"

Page 75, line 26, after the period, insert "Pressure support ventilators shall be paid the Medicare rate plus 47 percent."

Page 122, line 7, delete "4,232,594,000" and insert "4,068,928,000" and delete "4,385,195,000" and insert "4,159,822,000"

Page 122, line 10, delete "3,361,282,000" and insert "3,158,294,000" and delete "3,535,836,000" and insert "3,275,806,000"

Page 122, line 13, delete "867,038,000" and insert "906,360,000" and delete "845,085,000" and insert "879,742,000"

Page 123, line 16, delete "157,188,000" and insert "168,004,000" and delete "161,099,000" and insert "165,310,000"

Page 123, line 19, delete "20,709,000" and insert "16,966,000" and delete "20,709,000" and insert "16,966,000"

Page 123, after line 20, insert:

"**Background Studies; Appropriations.** (a) $2,074,000 in fiscal year 2022 is appropriated from the general fund to the commissioner of human services to provide a credit to providers who paid for emergency background studies in NETStudy 2.0.

(b) $2,061,000 in fiscal year 2022 is appropriated from the general fund to the commissioner of human services to cover the costs of reprocessing emergency studies conducted under interagency agreements with other agencies."

Reletter the paragraphs in sequence

Page 124, line 6, delete "$161,781,000" and insert "$160,470,000"

Page 124, line 7, delete "$161,934,000" and insert "$160,470,000"

Page 124, after line 7, insert:

"Subd. 4. **Central Office; Children and Family Services**

	Appropriations by Fund	
General	351,000	-0-

"

Page 124, line 10, delete "21,942,000" and insert "24,294,000" and delete "22,360,000" and insert "22,931,000"

Page 124, line 11, delete "24,313,000" and insert "28,168,000" and delete "24,313,000" and insert "28,168,000"

Page 124, line 26, delete "$23,453,000" and insert "$23,067,000"

Page 124, line 27, delete "$23,512,000" and insert "$23,067,000"

Page 124, after line 27, insert:

"Subd. 5. **Central Office; Continuing Care**

	Appropriations by Fund	
General	40,000	56,000

Base Level Adjustment. The general fund base is $0 in fiscal year 2024 and $0 in fiscal year 2025."

Renumber the subdivisions in sequence

Page 124, line 31, delete "207,373,000" and insert "246,583,000" and delete "184,499,000" and insert "219,044,000"

Page 125, line 4, delete "3,173,949,000" and insert "3,276,183,000" and delete "3,340,640,000" and insert "3,394,733,000"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly