..... moves to amend H.F. No. 2930, the first engrossment, as follows:

Page 21, delete lines 27 to 33 and insert "into a value-based purchasing arrangement under medical assistance or MinnesotaCare, by written arrangement with a drug manufacturer based on agreed-upon metrics. The commissioner may contract with a vendor to implement and administer the value-based purchasing arrangement. A value-based purchasing arrangement may include, but is not limited to: rebates, discounts, price reductions, risk sharing, reimbursements, guarantees, shared savings payments, withholds, or bonuses. A value-based purchasing arrangement must provide at least the same value or discount in"

Page 25, line 24, after "(l)" insert ", or, upon federal approval, for FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act, as provided under paragraph (k)"

Page 26, strike lines 24 to 31 and insert:

"(k) The commissioner shall establish an encounter payment rate that is equivalent to the all inclusive rate (AIR) payment established by the Indian Health Service and published in the Federal Register. The encounter rate must be updated annually and must reflect the changes in the AIR established by the Indian Health Service each calendar year. FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act may elect to be paid: (1) at the encounter rate established under this paragraph; (2) under the alternative payment methodology described in paragraph (l); or (3) under the federally required prospective payment system described in paragraph (f). FQHCs that elect to be paid at the encounter rate established under this paragraph must continue to meet all state and federal requirements related to FQHCs and urban Indian organizations, and must maintain their statuses as FQHCs and urban Indian organizations."

Page 30, after line 17, insert:

"**EFFECTIVE DATE.** This section is effective January 1, 2026, or upon federal approval, whichever is later, except that paragraph (m) is effective July 1, 2023. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained."

Page 32, after line 19, insert:

"Sec. 2. Minnesota Statutes 2022, section 256B.0625, subdivision 34, is amended to read:

Subd. 34. **Indian health services facilities.** ~~(a)~~ Medical assistance payments and MinnesotaCare payments to facilities of the Indian health service and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, for enrollees who are eligible for federal financial participation, shall be at the option of the facility in accordance with the rate published by the United States Assistant Secretary for Health under the authority of United States Code, title 42, sections 248(a) and 249(b). MinnesotaCare payments for enrollees who are not eligible for federal financial participation at facilities of the Indian health service and facilities operated by a tribe or tribal organization for the provision of outpatient medical services must be in accordance with the medical assistance rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization.

~~(b) Effective upon federal approval, the medical assistance payments to a dually certified facility as defined in subdivision 30, paragraph (j), shall be the encounter rate described in paragraph (a) or a rate that is substantially equivalent for services provided to American Indians and Alaskan Native populations. The rate established under this paragraph for dually certified facilities shall not apply to MinnesotaCare payments.~~

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained."

Page 49, line 11, delete "ten" and insert "20"

Page 51, line 6, delete "this section" and insert "sections 62J.0411 to 62J.0415"

Page 58, line 29, delete "commissioner" and insert "commission"

Page 66, line 25, delete "2024, 2025," and insert "2025"

Page 66, line 28, delete "and"

Page 66, after line 28, insert:

"(2) has a household income that does not exceed 400 percent of the federal poverty guidelines; and"

Page 66, line 29, delete "(2)" and insert "(3)"

Page 67, line 33, delete the comma and insert a period

Page 68, delete lines 1 and 2

Page 68, line 9, delete everything after the period

Page 68, delete lines 10 to 15

Page 68, line 16, delete "(c)" and insert "(b)"

Page 68, line 23, delete "may" and insert "shall"

Page 69, line 22, delete "providing" and insert "ensuring"

Page 69, line 23, delete "for all enrollees, including those" and insert ", especially for enrollees"

Page 69, line 26, delete "include" and insert "provide"

Page 69, line 30, after "methods" insert "or to replace these existing methods"

Page 70, line 7, delete "under medical assistance" and after "are" insert "age 65 or older,"

Page 70, line 8, delete everything after "disability" and insert a semicolon

Page 70, line 21, delete "financial" and insert "revenues and cost"

Page 70, after line 24, insert:

"(5) estimate the loss of revenues and cost savings from other payment enhancements based on managed care plan pass-throughs;"

Renumber the clauses in sequence

Page 73, line 4, delete "$....." and insert "$10,000,000. The commissioner shall calculate the aggregate difference in payments for outpatient pharmacy claims for medical assistance enrollees receiving services from a managed care or county-based purchasing plan, when reimbursed at the 340B rate as compared to the non-340B rate, as specified in section 256B.0625, subdivision 13e. The commissioner, by February 1, 2026, shall report the results of this calculation for the prior fiscal year, to the chairs and ranking members of the legislative committees with jurisdiction over health care policy and finance"

Page 77, line 31, delete "(a)"

Page 78, delete lines 11 to 21

Page 78, line 22, delete "The amendment to paragraph (a)" and insert "This section"

Page 78, line 24, delete everything after the period

Page 78, delete lines 25 to 27

Page 82, delete lines 22 to 25 and insert:

"(2) The rate described in clause (1) shall be increased for hospitals providing high levels of 340B drugs. The rate adjustment shall be based on four percent of each hospital's share of the total reimbursement for 340B drugs to all critical access hospitals, but shall not exceed $3,000,000."

Page 87, line 21, after "option" insert "under Minnesota Statutes, section 256L.04, subdivision 15"

Page 94, line 17, delete "in the settlement"

Page 94, line 18, delete "account established"

Page 95, delete section 5

Page 95, delete lines 26 to 31 and insert:

"Subd. 2. **Compliance.** The commissioner shall, to the extent practicable, seek the cooperation of health care providers and facilities, and may provide any support and assistance as available, in obtaining compliance with this section."

Page 96, line 2, delete "; COMPARISON TOOL"

Page 96, delete lines 28 and 29 and insert:

"(l) "Standard charge" means the regular rate established by the medical or dental practice for an item or service provided to a specific group of paying patients. This includes all of the following:

(1) the charge for an individual item or service that is reflected on a medical or dental practice's chargemaster, absent any discounts;

(2) the charge that a medical or dental practice has negotiated with a third-party payer for an item or service;

(3) the lowest charge that a medical or dental practice has negotiated with all third-party payers for an item or service;

(4) the highest charge that a medical or dental practice has negotiated with all third-party payers for an item or service; and

(5) the charge that applies to an individual who pays cash, or cash equivalent, for an item or service."

Page 100, line 27, after the semicolon, insert "and"

Page 102, line 20, after the semicolon, insert "and"

Page 105, line 27, delete "period"

Page 110, line 7, delete "Wholesaler" and insert "Wholesale drug distributor"

Page 110, lines 8, 10, and 11, delete "wholesaler" and insert "wholesale drug distributor"

Page 111, line 3, delete "wholesaler" and insert "wholesale drug distributor"

Page 123, line 28, after "lead" insert "at or"

Page 124, line 18, delete "at or"

Page 124, line 20, before "above" insert "at or"

Page 124, line 26, delete "at or"

Page 125, line 7, after "lead" insert "at or"

Page 125, line 10, delete "at or"

Page 126, line 21, after "with" insert "academic institutions, industry and community organizations, and"

Page 126, line 22, after "medicine," insert "and" and delete "academic institutions, and industry and"

Page 126, line 23, delete "community organizations"

Page 130, line 19, after "department" insert "and division" and delete the second "and division"

Page 135, line 10, delete "and"

Page 137, after line 13, insert:

"Sec. .... **[144.0759] PUBLIC HEALTH AMERICORPS.**

The commissioner may award a grant to a statewide, nonprofit organization to support Public Health AmeriCorps members. The organization awarded the grant shall provide the

commissioner with any information needed by the commissioner to evaluate the program in the form and according to timelines specified by the commissioner."

Page 147, delete section 52

Page 151, line 29, after "therapy," insert "dental, physician," and delete "and physician and dental"

Page 151, line 30, delete "programs"

Page 187, line 26, delete "Direct-care" and insert "Direct care" and delete "Direct-care" and insert "Direct care"

Page 193, line 13, delete "direct-care" and insert "direct care"

Page 215, line 1, delete "Mobile" and insert "mobile"

Page 215, line 2, delete "Crisis and Public Safety Answering Points" and insert "crisis and public safety answering points"

Page 215, line 14, delete "department" and insert "commissioner" and delete "and regulations"

Page 215, line 18, delete "The department"

Page 215, delete lines 19 and 20

Page 215, delete line 26 and insert "(f) The commissioner shall provide an annual public report on 988 Lifeline usage, including data on"

Page 215, delete subdivision 3 and insert:

"Subd. 3. **Activities to support the 988 system.** The commissioner shall use money appropriated for the 988 system to fund:

(1) implementing, maintaining, and improving the 988 Suicide and Crisis Lifeline to ensure the efficient and effective routing and handing of calls, chats, and texts made to the 988 Lifeline Centers, including staffing and technological infrastructure enhancements necessary to achieve operational standards and best practices set by the 988 Lifeline and the department;

(2) personnel for 988 Lifeline Centers;

(3) the provision of acute mental health and crisis outreach services to persons who contact a 988 Lifeline Center;

(4) publicizing and raising awareness of 988 services, or providing grants to organizations to publicize and raise awareness of 988 services;

(5) data collection, reporting, participation in evaluations, public promotion, and related quality improvement activities as required by the 988 administrator and the department; and

(6) administration, oversight, and evaluation.

Subd. 4. **988 Lifeline operating budget; data to legislature.** The commissioner shall provide to the legislature a biennial report for maintaining the 988 system. The report must include data on direct and indirect expenditures to maintain the 988 system."

Page 216, delete subdivision 4

Page 217, delete subdivision 5

Page 218, delete subdivisions 6 and 7

Page 222, line 15, delete everything after"sexuality" and insert ", reproduction, and the reproductive system and its functions and processes, and not merely the absence of disease or infirmity"

Page 222, delete line 16

Page 222, line 17, delete everything before the period

Page 222, line 31, after "criteria" insert "to use"

Page 226, line 2, after "solutions" insert "for"

Page 227, line 7, after "solutions" insert "for"

Page 227, line 20, after "Black" insert "communities"

Page 229, line 9, before "By" insert "(a)" and after "licensed" insert "or certified"

Page 229, after line 14, insert:

"(b) For purposes of this section, "licensed or certified child care provider" means a child care center licensed under Minnesota Rules, chapter 9503, or a certified license-exempt child care center under chapter 245H."

Page 229, lines 18 and 21, after "licensed" insert "or certified"

Page 229, line 26, delete the second comma

Page 229, line 29, after "licensed" insert "or certified"

Page 230, line 1, after "licensed" insert "or certified"

Page 231, line 24, after "Health" insert "Services"

Page 232, lines 14, 15, and 20, delete "can demonstrate" and insert "demonstrates"

Page 232, line 21, delete "can" and insert "may"

Page 265, delete section 177

Page 267, delete section 178

Page 283, line 16, delete "5" and insert "5a"

Page 284, line 5, after "children" insert "from"

Page 284, line 8, delete ". Support" and insert "and support"

Page 284, line 32, after "implement" insert ", without compromising the safety or security of the correctional facility,"

Page 285, line 2, delete everything before the period

Page 289, delete lines 4 and 5 and insert:

"(2) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the house minority leader, and two members of the senate, one appointed by the senate majority leader and one appointed by the senate minority leader;"

Page 289, line 20, delete "physician" and insert "psychiatrist"

Page 293, after line 7, insert:

"Sec. .... **SKIN-LIGHTENING PRODUCTS PUBLIC AWARENESS AND EDUCATION GRANT.**

An organization receiving a grant from the commissioner of health for public awareness and education activities to address issues of colorism, skin-lightening products, and chemical exposure from skin-lightening products must use the grant funds for activities that are culturally specific and community-based and that focus on:

(1) increasing public awareness and providing education on the health dangers associated with using skin-lightening creams and products that contain mercury and hydroquinone and are manufactured in other countries, brought into this country, and sold illegally online or in stores; the dangers of exposure to mercury through dermal absorption, inhalation, hand-to-mouth contact, and contact with individuals who have used these skin-lightening products; the health effects of mercury poisoning, including the permanent effects on the

central nervous system and kidneys; and the dangers to mothers and infants of using these products or being exposed to these products during pregnancy and while breastfeeding;

(2) identifying products that contain mercury and hydroquinone by testing skin-lightening products;

(3) developing a train the trainer curriculum to increase community knowledge and influence behavior changes by training community leaders, cultural brokers, community health workers, and educators;

(4) continuing to build the self-esteem and overall wellness of young people who are using skin-lightening products or are at risk of starting the practice of skin lightening; and

(5) building the capacity of community-based organizations to continue to combat skin-lightening practices and chemical exposures from skin-lightening products.

Sec. .... **STATEWIDE HEALTH CARE PROVIDER DIRECTORY.**

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

(b) "Health care provider" means a practicing provider that accepts reimbursement from a group purchaser.

(c) "Health care provider directory" means an electronic catalog and index that supports the management of health care provider information, both individual and organizational, in a directory structure for public use to find available providers and networks and support state agency responsibilities.

(d) "Group purchaser" has the meaning given in Minnesota Statutes, section 62J.03, subdivision 6.

Subd. 2. **Health care provider directory.** The commissioner shall assess the feasibility and stakeholder commitment to develop, manage, and maintain a statewide electronic directory of health care providers. The assessment must take into consideration consumer information needs, state agency applications, stakeholder needs, technical requirements, alignment with national standards, governance, operations, legal and policy considerations, and existing directories. The commissioner shall conduct this assessment in consultation with stakeholders, including but not limited to consumers, group purchasers, health care providers, community health boards, and state agencies."

Page 293, line 22, delete "deny" and insert "disapprove"

Page 294, line 30, delete "the their"

Page 295, line 1, after "physician's" insert ", advanced practice registered nurse's, or physician assistant's"

Page 328, line 3, strike "$125" and insert "$225"

Page 368, line 5, delete "this" and insert "the grant"

Page 368, line 13, delete "subdivision" and insert "section" and delete the second "section" and insert "subdivision"

Page 375, line 13, after "notice" insert "to an applicant for CCBHC certification"

Page 376, line 4, delete "complete via" and insert "completed using"

Page 409, after line 27, insert:

"Sec. .... Minnesota Statutes 2022, section 256B.0624, subdivision 5, is amended to read:

Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Qualified individual staff of a qualified provider entity must provide crisis assessment and intervention services to a recipient. A staff member providing crisis assessment and intervention services to a recipient must be qualified as a:

(1) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health certified peer specialist.

(b) When crisis assessment and intervention services are provided to a recipient in the community, a mental health professional, clinical trainee, or mental health practitioner must lead the response.

(c) The 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce the recipient's risk of suicide and self-injurious behavior.

(d) At least six hours of the ongoing training under paragraph (c) must be specific to working with families and providing crisis stabilization services to children and include the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

~~(d)~~ (e) Team members must be experienced in crisis assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources.

Sec. .... Minnesota Statutes 2022, section 256B.0624, subdivision 8, is amended to read:

Subd. 8. **Crisis stabilization staff qualifications.** (a) Mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. A staff member providing crisis stabilization services to a recipient must be qualified as a:

(1) mental health professional;

(2) certified rehabilitation specialist;

(3) clinical trainee;

(4) mental health practitioner;

(5) mental health certified family peer specialist;

(6) mental health certified peer specialist; or

(7) mental health rehabilitation worker.

(b) The 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce a recipient's risk of suicide and self-injurious behavior.

(c) For providers who deliver care to children 21 years of age and younger, at least six hours of the ongoing training under this subdivision must be specific to working with families and providing crisis stabilization services to children and include the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

This paragraph does not apply to adult residential crisis stabilization service providers licensed according to section 245I.23.

Sec. .... Minnesota Statutes 2022, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers services provided by a not-for-profit certified community behavioral health clinic (CCBHC) that meets the requirements of section 245.735, subdivision 3.

(b) The commissioner shall reimburse CCBHCs on a per-day basis for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical assistance payments as described in paragraph (c). The commissioner shall include a quality incentive payment in the CCBHC daily bundled rate system as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC daily bundled rate system.

(c) The commissioner shall ensure that the CCBHC daily bundled rate system for CCBHC payments under medical assistance meets the following requirements:

(1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not

covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment shall be limited to one payment per day per medical assistance enrollee when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) initial CCBHC daily bundled rates for newly certified CCBHCs under section 245.735, subdivision 3, shall be established by the commissioner using a provider-specific rate based on the newly certified CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner shall rebase CCBHC rates once every ~~three~~ two years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services;

(5) the commissioner shall provide for a 60-day appeals process after notice of the results of the rebasing;

(6) ~~the CCBHC daily bundled rate under this section does not apply to services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. An entity that receives a CCBHC daily bundled rate system that overlaps with the CCBHC rate is not eligible for the CCBHC rate~~ if the commissioner has not reentered the CCBHC demonstration program by July 1, 2023, CCBHCs shall be paid the daily bundled rate under this section for services rendered to individuals who are duly eligible for Medicare and medical assistance;

(7) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the CCBHC daily bundled rate system in the Medicaid Management Information System (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

(8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each provider-specific rate by the Medicare Economic Index for primary care services. This update shall occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Estimated costs are subject to review by the commissioner. Rate adjustments for changes in scope shall occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

(d) Managed care plans and county-based purchasing plans shall reimburse CCBHC providers at the CCBHC daily bundled rate. The commissioner shall monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

(e) The commissioner shall implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments for which the CCBHC is eligible under the CCBHC daily bundled rate system described in paragraph (c);

(2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC shall receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner shall notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section shall be submitted directly to, and paid by, the commissioner on the dates specified no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42, section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by managed care plans.

If the conditions in this paragraph are met between January 1 and June 30 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on January 1 of the following year. If the conditions in this paragraph are met between July 1 and December 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on July 1 of the following year.

(g) Peer services provided by a CCBHC certified under section 245.735 are a covered service under medical assistance when a licensed mental health professional or alcohol and drug counselor determines that peer services are medically necessary. Eligibility under this subdivision for peer services provided by a CCBHC supersede eligibility standards under sections 256B.0615, 256B.0616, and 245G. 07, subdivision 2, clause (8).

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained."

Pages 411 to 413, delete sections 53 to 55

Page 499, after line 10, insert:

"Sec. .... Minnesota Statutes 2022, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the agency may negotiate a payment not to exceed ~~$426.37~~ $531.12 for other

services necessary to provide room and board if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient in the residence under ~~a~~ the following programs or funding sources: (1) home and community-based waiver services under ~~title XIX of the federal Social Security Act~~ chapter 256S or sections 256B.0913, 256B.092, or 256B.49; ~~or funding from the medical assistance program~~ (2) personal care assistance under section 256B.0659~~, for personal care services for residents in the setting~~; ~~or residing in a setting which receives funding under~~ (3) community first services and supports under section 256B.85; or (4) services for adults with mental illness grants under section 245.73. If funding is available for other necessary services through a home and community-based waiver~~, or~~ under chapter 256S, or sections 256B.0913, 256B.092, or 256B.49; personal care assistance services under section 256B.0659~~,~~; community first services and supports under section 256B.85; or services for adults with mental illness grants under section 245.73, then the housing support rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service rate exceed ~~$426.37~~ $531.12. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. ~~The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the federal Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or substance use disorder and shall apply for a waiver if it is determined to be cost-effective.~~

(b) The commissioner is authorized to make cost-neutral transfers from the housing support fund for beds under this section to other funding programs administered by the department after consultation with the agency in which the affected beds are located. The commissioner may also make cost-neutral transfers from the housing support fund to agencies for beds permanently removed from the housing support census under a plan submitted by the agency and approved by the commissioner. The commissioner shall report the amount of any transfers under this provision annually to the legislature.

(c) Agencies must not negotiate supplementary service rates with providers of housing support that are licensed as board and lodging with special services and that do not encourage

a policy of sobriety on their premises and make referrals to available community services for volunteer and employment opportunities for residents.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. .... Minnesota Statutes 2022, section 256I.05, subdivision 2, is amended to read:

Subd. 2. **Monthly rates; exemptions.** This subdivision applies to a residence that on August 1, 1984, was licensed by the commissioner of health only as a boarding care home, certified by the commissioner of health as an intermediate care facility, and licensed by the commissioner of human services under Minnesota Rules, parts 9520.0500 to 9520.0670. Notwithstanding the provisions of subdivision 1c, the rate paid to a facility reimbursed under this subdivision shall be determined under chapter 256R, if the facility is accepted by the commissioner for participation in the alternative payment demonstration project. The rate paid to this facility shall also include adjustments to the room and board rate according to subdivision 1~~, and any adjustments applicable to supplemental service rates statewide~~.

Sec. .... **HOUSING SUPPORT SUPPLEMENTARY SERVICE RATE STUDY.**

(a) The commissioner of human services, in consultation with residents of housing support settings, providers, and lead agencies, must analyze housing support supplementary service rates under Minnesota Statutes, section 256I.05, to recommend a rate setting methodology that is person-centered, equitable, and adequately covers the cost to provide services. The analysis must include, but is not limited to:

(1) a review of current supplemental rates;

(2) recommendations to avoid duplication of services, while ensuring informed choice; and

(3) recommendations on an updated rate setting methodology.

(b) By January 15, 2026, the commissioner must submit a report, including recommendations and draft legislative language, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance."

Page 512, line 17, after the period, insert "For purposes of this section, when a denial order is issued through the provider licensing and reporting hub, the applicant is deemed to have received the order upon the date of issuance through the hub."

Page 521, after line 19, insert:

"Sec. .... Minnesota Statutes 2022, section 62K.10, subdivision 4, is amended to read:

Subd. 4. **Network adequacy.** (a) Each designated provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance use disorder services, to ensure that covered services are available to all enrollees without unreasonable delay. In determining network adequacy, the commissioner of health shall consider availability of services, including the following:

(1) primary care physician services are available and accessible 24 hours per day, seven days per week, within the network area;

(2) a sufficient number of primary care physicians have hospital admitting privileges at one or more participating hospitals within the network area so that necessary admissions are made on a timely basis consistent with generally accepted practice parameters;

(3) specialty physician service is available through the network or contract arrangement;

(4) mental health and substance use disorder treatment providers are available and accessible through the network or contract arrangement;

(5) to the extent that primary care services are provided through primary care providers other than physicians, and to the extent permitted under applicable scope of practice in state law for a given provider, these services shall be available and accessible; and

(6) the network has available, either directly or through arrangements, appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of enrollees for covered health care services.

(b) The commissioner must determine network sufficiency in a manner that is consistent with the requirements of this section and may establish network sufficiency by referencing any reasonable criteria, which may include but is not limited to:

(1) provider to covered person ratios by specialty;

(2) primary care provider to covered person ratios;

(3) geographic accessibility of providers;

(4) geographic variation and population dispersion;

(5) waiting times for an appointment with a participating provider;

(6) hours of operation;

(7) the ability of the network to meet the needs of covered persons, which may include: (i) low-income persons; (ii) children and adults with serious, chronic, or complex health

conditions, physical disabilities, or mental illness; or (iii) persons with limited English proficiency and persons from underserved communities;

(8) other health care service delivery system options, including telehealth, mobile clinics, and centers of excellence; and

(9) the availability of technological and specialty care services to meet the needs of covered persons requiring technologically advanced or specialty care services.

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to health plans offered, issued, or renewed on or after that date.

Sec. .... Minnesota Statutes 2022, section 62Q.096, is amended to read:

62Q.096 CREDENTIALING OF PROVIDERS.

(a) If a health plan company has initially credentialed, as providers in its provider network, individual providers employed by or under contract with an entity that:

(1) is authorized to bill under section 256B.0625, subdivision 5;

(2) is a mental health clinic certified under section 245I.20;

(3) is designated an essential community provider under section 62Q.19; and

(4) is under contract with the health plan company to provide mental health services, the health plan company must continue to credential at least the same number of providers from that entity, as long as those providers meet the health plan company's credentialing standards.

(b) In order to ensure timely access by patients to mental health services, between July 1, 2023, and June 30, 2025, a health plan company must credential and enter into a contract for mental health services with any provider of mental health services that:

(1) meets the health plan company's credential requirements. For purposes of credentialing under this paragraph, a health plan company may waive credentialing requirements that are not directly related to quality of care in order to ensure patient access to providers from underserved communities or to providers in rural areas;

(2) seeks a credential from the health plan company;

(3) agrees to the health plan company's contract terms. The contract shall include payment rates that are usual and customary for the services provided;

(4) is accepting new patients; and

(5) is not already under a contract with the health plan company under a separate tax identification number or, if already under a contract with the health plan company, has provided notice to the health plan company of termination of the existing contract.

(c) A health plan company shall not refuse to credential these providers on the grounds that their provider network has:

(1) a sufficient number of providers of that type, including but not limited to the provider types identified in paragraph (a); or

(2) a sufficient number of providers of mental health services in the aggregate.

Sec. .... Minnesota Statutes 2022, section 62Q.47, is amended to read:

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) A health plan company must not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

(e) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

(f) The commissioner may require information from health plan companies to confirm that mental health parity is being implemented by the health plan company. Information required may include comparisons between mental health and substance use disorder treatment and other medical conditions, including a comparison of prior authorization requirements, drug formulary design, claim denials, rehabilitation services, and other information the commissioner deems appropriate.

(g) Regardless of the health care provider's professional license, if the service provided is consistent with the provider's scope of practice and the health plan company's credentialing and contracting provisions, mental health therapy visits and medication maintenance visits shall be considered primary care visits for the purpose of applying any enrollee cost-sharing requirements imposed under the enrollee's health plan.

(h) By June 1 of each year, beginning June 1, 2021, the commissioner of commerce, in consultation with the commissioner of health, shall submit a report on compliance and oversight to the chairs and ranking minority members of the legislative committees with jurisdiction over health and commerce. The report must:

(1) describe the commissioner's process for reviewing health plan company compliance with United States Code, title 42, section 18031(j), any federal regulations or guidance relating to compliance and oversight, and compliance with this section and section 62Q.53;

(2) identify any enforcement actions taken by either commissioner during the preceding 12-month period regarding compliance with parity for mental health and substance use disorders benefits under state and federal law, summarizing the results of any market conduct examinations. The summary must include: (i) the number of formal enforcement actions taken; (ii) the benefit classifications examined in each enforcement action; and (iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations;

(3) detail any corrective action taken by either commissioner to ensure health plan company compliance with this section, section 62Q.53, and United States Code, title 42, section 18031(j); and

(4) describe the information provided by either commissioner to the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law.

The report must be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites. Individually identifiable information must be excluded from the report, consistent with state and federal privacy protections.

(i) The commissioner must require health plans with contracts under section 256B.69 to use the timely filing timelines and prior authorization processes consistent with medical assistance fee-for-service for mental health and substance use disorder services covered under medical assistance."

Page 528, after line 31, insert:

"Sec. .... **GEOGRAPHIC ACCESSIBILITY AND NETWORK ADEQUACY STUDY.**

(a) The commissioner of health, in consultation with the commissioner of commerce and stakeholders, must study and develop recommendations on additional methods, other than maximum distance and travel times for enrollees, to determine adequate geographic accessibility of health care providers and the adequacy of health care provider networks maintained by health plan companies. The commissioner may examine the effectiveness and feasibility of using the following methods to determine geographic accessibility and network adequacy:

(1) establishing ratios of providers to enrollees by provider specialty;

(2) establishing ratios of primary care providers to enrollees; and

(3) establishing maximum waiting times for appointments with participating providers.

(b) The commissioner must examine:

(1) geographic accessibility of providers under current law;

(2) geographic variation and population dispersion;

(3) how provider hours of operations limit access to care;

(4) the ability of existing networks to meet the needs of enrollees, which may include low-income persons; children and adults with serious, chronic, or complex health conditions, physical disabilities, or mental illness; or persons with limited English proficiency and persons from underserved communities;

(5) other health care service delivery options, including telehealth, mobile clinics, and centers of excellence; and

(6) the availability of services needed to meet the needs of enrollees requiring technologically advanced or specialty care services.

(c) The commissioner must submit to the legislature a report on the study and recommendations required by this section no later than January 15, 2024."

Page 531, line 3, delete "3,097,936,000" and insert "3,093,744,000" and delete "3,099,393,000" and insert "3,094,666,000"

Page 531, line 6, delete "2,015,892,000" and insert "2,001,487,000" and delete "1,720,282,000" and insert "1,677,851,000"

Page 531, line 9, delete "999,810,000" and insert "1,010,023,000" and delete "1,298,385,000" and insert "1,336,089,000"

Page 535, line 2, delete "286,688,000" and insert "282,251,000" and delete "249,734,000" and insert "245,773,000"

Page 536, line 9, delete "$221,875,000" and insert "$221,687,000"

Page 536, line 10, delete "$238,783,000" and insert "$238,595,000"

Page 536, line 20, delete "36,316,000" and insert "36,291,000"

Page 537, line 5, delete "$50,462,000" and insert "$50,332,000"

Page 537, line 6, delete "$64,939,000" and insert "$64,809,000"

Page 537, line 15, delete "27,739,000" and insert "27,980,000" and delete "27,862,000" and insert "28,227,000"

Page 537, line 29, delete "$26,107,000" and insert "$26,472,000"

Page 537, line 30, delete "$25,746,000" and insert "$25,911,000"

Page 538, line 9, delete "211,692,000" and insert "213,786,000" and delete "224,225,000" and insert "228,244,000"

Page 538, line 10, delete "89,306,000" and insert "88,889,000" and delete "60,533,000" and insert "59,513,000"

Page 538, line 16, delete "1,078,348,000" and insert "1,066,045,000" and delete "791,406,000" and insert "748,577,000"

Page 538, line 17, delete "869,524,000" and insert "880,154,000" and delete "1,194,975,000" and insert "1,233,699,000"

Page 538, line 19, delete "$589,959,000" and insert "$591,957,000"

Page 538, line 20, delete "$1,147,261,000" and insert "$1,197,599,000"

Page 541, line 28, delete "473,085,000" and insert "472,644,000" and delete "435,666,000" and insert "436,192,000"

Page 541, line 31, delete "326,653,000" and insert "331,125,000" and delete "279,093,000" and insert "289,444,000"

Page 542, line 8, delete "268,786,000" and insert "273,258,000" and delete "225,336,000" and insert "235,687,000"

Page 546, line 4, delete "$6,120,000" and insert "$5,720,000"

Page 546, line 5, delete "$7,400,000" and insert "$7,000,000"

Page 546, line 9, delete "$6,850,000" and insert "$6,450,000" and delete "$7,100,000" and insert "$6,700,000"

Page 546, delete lines 31 to 33

Page 547, delete lines 1 and 2

Renumber the clauses in sequence

Page 552, line 2, delete "$100,000" and insert "$199,000"

Page 552, line 3, delete "is" and insert "and $100,000 in fiscal year 2025 are"

Page 552, line 15, delete "$200,000" and insert "$338,000" and delete "$200,000" and insert "$171,000"

Page 552, after line 23, insert:

"(ee) **988 Lifeline System.** $8,504,000 in fiscal year 2024 and $8,504,000 in fiscal year 2025 are from the general fund for activities to support the 988 Lifeline system.

(ff) **Network Adequacy.** $798,000 in fiscal year 2024 and $491,000 in fiscal year 2025 are from the general fund for costs related to reviews of provider networks to determine

network adequacy and a geographic accessibility and network adequacy study.

(gg) **Skin-Lightening Products Public Awareness and Education Grant.** $121,000 in fiscal year 2024 and $121,000 in fiscal year 2025 are from the general fund for a grant to the Beautywell Project for public awareness and education activities to address issues of colorism, skin-lightening products, and chemical exposures from these products. Of these appropriations, the commissioner may use up to $21,000 in fiscal year 2024 and $21,000 in fiscal year 2025 for administration. This is a onetime appropriation."

Reletter the paragraphs in sequence

Page 554, line 2, delete "$193,895,000" and insert "$203,876,000"

Page 554, line 3, delete "$193,403,000" and insert "$203,384,000"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly