..... moves to amend H.F. No. 2128, the delete everything amendment (H2128DE2), as follows:

Page 30, after line 14, insert:

"Sec. 27. Minnesota Statutes 2020, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be ~~$10.48~~ $10.77 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be ~~$10.48~~ $10.77 per ~~bag~~ claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be ~~$10.48~~ $10.77 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered

outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC of the generic product or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f,

paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(f) The commissioner may establish maximum allowable cost rates for specialty pharmacy products that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the maximum allowable cost to prevent access to care issues.

(g) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

(h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for specialty prescription drugs and a single statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement.

(i) The commissioner shall increase the ingredient cost reimbursement calculated in paragraphs (a) and (f) by 1.8 percent for prescription and nonprescription drugs subject to the wholesale drug distributor tax under section 295.52."

Page 66, delete section 49

Page 70, delete section 50

Page 169, after line 26, insert:

"Sec. .... **[62J.826] MEDICAL PRACTICES; CURRENT STANDARD CHARGES; COMPARISON TOOL.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Chargemaster" means the list of all individual items and services maintained by a medical practice for which the medical practice has established a charge.

(c) "Diagnostic laboratory testing" means a service charged using a CPT code within the CPT code range of 80047 to 89398.

(d) "Diagnostic radiology service" means a service charged using a CPT code within the CPT code range of 70010 to 7999 and includes the provision of x-rays, computed

tomography scans, positron emission tomography scans, magnetic resonance imaging scans, and mammographies.

(e) "Hospital" means an acute care institution licensed under sections 144.50 to 144.58, but does not include a health care institution conducted for those who rely primarily upon treatment by prayer or spiritual means in accordance with the creed or tenets of any church or denomination.

(f) "Medical practice" means a business that:

(1) earns revenue by providing medical care to the public;

(2) issues payment claims to health plan companies and other payers; and

(3) may be identified by its federal tax identification number.

(g) "Outpatient surgical center" means a health care facility other than a hospital offering elective outpatient surgery under a license issued under sections 144.50 to 144.58.

Subd. 2. **Requirement; current standard charges.** The following medical practices must make available to the public a list of their current standard charges, as reflected in the medical practice's chargemaster, for all items and services provided by the medical practice:

(1) hospitals;

(2) outpatient surgical centers; and

(3) any other medical practice that has revenue of greater than $50,000,000 per year and that derives the majority of its revenue by providing one or more of the following services:

(i) diagnostic radiology services;

(ii) diagnostic laboratory testing;

(iii) orthopedic surgical procedures, including joint arthroplasty procedures within the CPT code range of 26990 to 27899;

(iv) ophthalmologic surgical procedures, including cataract surgery coded using CPT code 66982 or 66984, or refractive correction surgery to improve visual acuity;

(v) anesthesia services commonly provided as an ancillary to services provided at a hospital, outpatient surgical center, or medical practice that provides orthopedic surgical procedures or ophthalmologic surgical procedures; or

(vi) oncology services, including radiation oncology treatments within the CPT code range of 77261 to 77799 and drug infusions.

Subd. 3. **Required file format and data attributes.** (a) A medical practice required to post its current standard charges must post the following data attributes in the listed order:

(1) federal tax identification number for the medical practice;

(2) name of the medical practice, defined as the provider name that the medical practice enters on the CMS claim form 1500 or a successor form when it submits health care claims to a payer organization;

(3) internal chargemaster record identification, defined as the internal record identifier for this chargemaster line item in the medical practice's billing system;

(4) service billing code system, defined as a code signifying the HIPAA-compliant billing code system from which the service billing code was drawn;

(5) service billing code, defined as a specific billing code drawn from the service billing code system denoted by the value in the service billing code type field;

(6) service description, defined as the shortest, nonabbreviated official description associated with the service billing code in the applicable service billing code system;

(7) revenue code, defined as the National Uniform Billing Committee revenue code denoting the patient's location within the medical practice where the patient will receive the item or service subject to this charge. This value is required only if the charge amount is dependent on the location within the medical practice where the item or service is provided;

(8) revenue code description, defined as the description provided by the National Uniform Billing Committee for the revenue code. This value is required only if the charge amount is dependent on the location within the medical practice where the item or service is provided;

(9) national drug code, defined as the national drug code for a drug that is administered as part of the service subject to this charge. This field is required only when the charge amount is dependent on which, if any, drug is being administered as part of this service;

(10) national drug code description, defined as the official description associated with the national drug code for a drug that is administered as part of the service subject to this charge. This field is required only when the charge amount is dependent on which, if any, drug is being administered as part of this service;

(11) inpatient gross charge, defined as the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts as defined in Code of Federal Regulations, title 45, section 180.20, for an item or service provided on an inpatient basis;

(12) outpatient gross charge, defined as the charge for an individual item or service that is reflected on a chargemaster, absent any discounts as defined in Code of Federal Regulations, title 45, section 180.20, for an item or service provided on an outpatient basis;

(13) inpatient discounted cash price, defined as the charge that applies to an individual who pays cash or a cash equivalent for an item or service being reported under this section and provided on an inpatient basis;

(14) outpatient discounted cash price, defined as the charge that applies to an individual who pays cash or a cash equivalent for an item or service being reported under this section and provided on an outpatient basis;

(15) charge unit, defined as the unit cost basis for the charge;

(16) effective date of the charge; and

(17) payer-specific negotiated charges, as defined in Code of Federal Regulations, title 45, section 180.20. There must be a separate field for each payer's rate, and the payers must be listed in alphabetical order.

(b) The data attributes specified in paragraph (a) must be posted in the form of a comma-separated values file, with all text values quoted and all leading and trailing white spaces trimmed before and after data attribute values.

(c) The data attributes specified in paragraph (a) must be posted on a web page labeled "Cost of Care at [Name of Medical Practice]" which members of the public can access via a direct, clearly labeled link on the medical practice's main billing web page, and which is searchable by entering the words "cost of care at [name of medical practice]" into an Internet search engine. The consumer-friendly list of standard charges for a limited set of shoppable services required under Code of Federal Regulations, title 45, section 180.60, must be presented on the same web page.

(d) The file must be named according to the following convention: <ein>_<hospital-name>_standardcharges.csv as required by Code of Federal Regulations, title 45, section 180.50.

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

Page 267, line 24, delete "list of presumptions" and insert "presumption"

Page 284, after line 21, insert:

"Subd. 4. **Exclusion.** This section does not apply to health coverage provided through the State Employee Group Insurance Plan (SEGIP) under chapter 43A."

Page 286, delete section 11

Page 325, after line 25, insert:

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

Page 328, line 29, delete everything after "effective" and insert "January 1, 2022."

Page 329, after line 11, insert:

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

Page 329, after line 31, insert:

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

Page 337, after line 16, insert:

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

Page 339, after line 15, insert:

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

Page 361, delete section 27

Page 361, delete lines 22 to 25 and insert:

"(a) Sections 1 to 15, 20, and 21 expire July 1, 2023."

Page 362, line 4, after "repealed" insert "January 1, 2022 and are revived and reenacted July 1, 2023"

Page 362, line 6, after "approval" insert "and are revived and reenacted July 1, 2023"

Page 406, line 4, reinstate "need" and delete "must"

Page 406, line 5, reinstate the stricken language

Page 406, line 6, delete the new language and reinstate the stricken language

Page 508, after line 32, insert:

"Sec. .... **DIRECTION TO THE COMMISSIONER; TRIBAL OVERPAYMENT PROTOCOLS.**

The commissioner of human services, in consultation with the tribal nations, shall develop protocols that must be used to address and attempt to resolve any future overpayment involving any tribal nation in Minnesota."

Page 515, after line 25, insert:

"Sec. .... Minnesota Statutes 2020, section 256.9741, subdivision 1, is amended to read:

Subdivision 1. **Long-term care facility.** "Long-term care facility" means a nursing home licensed under sections 144A.02 to 144A.10; a boarding care home licensed under sections 144.50 to 144.56; an assisted living facility or an assisted living facility with dementia care licensed under chapter 144G; ~~or~~ a licensed or registered residential setting that provides or arranges for the provision of home care services; or a setting defined under section 144G.08, subdivision 7, clauses (10) to (13), that provides or arranges for the provision of home care services.

**EFFECTIVE DATE.** This section is effective August 1, 2021."

Page 564, delete subdivision 9 and insert:

"Subd. 9. **Self-directed services workforce.** Nothing in this section limits the commissioner's authority over terms and conditions for individual providers in covered programs as defined in section 256B.0711. The commissioner's authority over terms and conditions for individual providers in covered programs remains subject to the state's obligations to meet and negotiate under chapter 179A, as modified and made applicable to individual providers under section 179A.54, and to agreements with any exclusive representative of individual providers, as authorized by chapter 179A, as modified and made applicable to individual providers under section 179A.54. A change in the rate for services within the covered programs defined in section 256B.0711 does not constitute a change in a term or condition for individual providers in covered programs and is not subject to the state's obligation to meet and negotiate under chapter 179A, except that, notwithstanding any other law to the contrary, the state shall meet and negotiate with the exclusive representative of individual providers over wage and benefit increases made possible by rate increases provided between January 1, 2023 and June 30, 2023. Any resulting tentative agreement shall be submitted to the legislature to be accepted or rejected in accordance with sections 3.855 and 179A.22."

Page 569, line 26, before "To" insert "(a)"

Page 569, line 30, after "services" insert ": (i)" and delete "(10)" and insert "(11)"

Page 569, line 31, after "(13)" insert "; or (ii) in an affordable housing setting under section 144G.08, subdivision 7, clause (10), that is delivering authorized customized living services to a person in the setting on or before April 1, 2021"

Page 569, after line 31, insert:

"(b) Settings under paragraph (a), clause (2), must comply with section 256S.2003.

**EFFECTIVE DATE.** This section is effective August 1, 2021."

Page 570, before line 1, insert:

"Sec. .... **[256S.2003] CUSTOMIZED LIVING SERVICES; REQUIREMENTS OF PROVIDERS IN DESIGNATED SETTINGS.**

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

(b) "Designated setting" means a setting defined under section 256S.20, subdivision 1, paragraph (a), clause (2).

(c) "Designated provider" means a home care provider licensed under chapter 144A that provides customized living services to some or all of the residents of a designated setting and that is either the setting itself or another entity with which the setting has a contract or business relationship.

(d) "Resident" means a person receiving customized living services in a designated setting.

Subd. 2. **Attestation of compliance with requirements.** Upon enrollment with the department to provide customized living services, a designated provider of customized living services must submit an attestation that the provider is in compliance with subdivisions 3 to 8.

Subd. 3. **Contracts.** (a) Every designated provider must execute a written contract with a resident or the resident's representative and must operate in accordance with the terms of the contract. The resident or the resident's representative must be given a complete copy of the contract and all supporting documents and attachments and any changes whenever changes are made.

(b) The contract must include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the designated provider;

(2) the name and mailing address of the owner or owners of the designated provider and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the designated provider, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement identifying the designated provider's home care license number;

(6) the term of the contract;

(7) an itemization and description of the services to be provided to the resident;

(8) a conspicuous notice informing the resident of the policy concerning the conditions under which and the process through which the contract may be modified, amended, or terminated;

(9) a description of the designated provider's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(10) the resident's designated representative, if any;

(11) the designated provider's referral procedures if the contract is terminated;

(12) a statement regarding the ability of a resident to receive services from service providers with whom the designated provider does not have an arrangement;

(13) a statement regarding the availability of public funds for payment for residence or services; and

(14) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

(c) The contract must include a statement regarding:

(1) the ability of a resident to furnish and decorate the resident's unit within the terms of the lease;

(2) a resident's right to access food at any time;

(3) a resident's right to choose the resident's visitors and times of visits;

(4) a resident's right to choose a roommate if sharing a unit; and

(5) a resident's right to have and use a lockable door to the resident's unit. The designated setting must provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible.

(d) A restriction of a resident's rights under this subdivision is allowed only if determined necessary for health and safety reasons identified by the home care provider's registered nurse in an initial assessment or reassessment, as defined under section 144A.4791, subdivision 8, and documented in the written service plan under section 144A.4791, subdivision 9. Any restrictions of those rights for people served under this chapter and section 256B.49 must be documented in the resident's coordinated service and support plan, as defined under sections 256B.49, subdivision 15, and 256S.10.

(e) The contract and related documents executed by each resident or resident's representative must be maintained by the designated provider in files from the date of execution until three years after the contract is terminated.

Subd. 4. **Training in dementia.** (a) If a designated provider has a special program or special care unit for residents with Alzheimer's disease or other dementias or advertises, markets, or otherwise promotes the provision of services for persons with Alzheimer's disease or other dementias, whether in a segregated or general unit, employees of the provider must meet the following training requirements:

(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;

(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b), or a supervisor meeting the requirements in clause (1), must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;

(3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and

(4) new employees may satisfy the initial training requirements under clauses (1) to (3) by producing written proof of previously completed required training within the past 18 months.

(b) Areas of required training include:

(1) an explanation of Alzheimer's disease and related disorders;

(2) assistance with activities of daily living;

(3) problem solving with challenging behaviors; and

(4) communication skills.

(c) The provider must provide to residents and prospective residents in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.

Subd. 5. **Restraints.** Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience.

Subd. 6. **Termination of contract.** A designated provider must include with notice of termination of contract information about how to contact the ombudsman for long-term care, including the address and telephone number along with a statement of how to request problem-solving assistance.

Subd. 7. **Manager requirements.** (a) The person primarily responsible for oversight and management of the designated provider, as designated by the owner, must obtain at least 30 hours of continuing education every two years of employment as the manager in topics relevant to the operations of the facility and the needs of its tenants. Continuing education earned to maintain a professional license, such as a nursing home administrator license, nursing license, social worker license, or real estate license, can be used to complete this requirement.

(b) New managers may satisfy the initial dementia training requirements by producing written proof of previously completed required training within the past 18 months.

Subd. 8. **Emergency planning.** (a) Each designated provider must meet the following requirements:

(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in-place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;

(2) prominently post an emergency disaster plan;

(3) provide building emergency exit diagrams to all residents upon signing a contract;

(4) post emergency exit diagrams on each floor; and

(5) have a written policy and procedure regarding missing residents.

(b) Each designated provider must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training available to all residents annually. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.

(c) Each designated provider location must conduct and document a fire drill or other emergency drill at least once every six months. To the extent possible, drills must be coordinated with local fire departments or other community emergency resources.

Subd. 9. **Other laws.** Each designated provider must comply with chapter 504B, and must obtain and maintain all other licenses, permits, registrations, or other required governmental approvals. A designated provider is not required to obtain a lodging license under chapter 157 and related rules.

**EFFECTIVE DATE.** This section is effective August 1, 2021."

Page 571, after line 17, insert:

"Sec. .... **DIRECTION TO COMMISSIONER; PROVIDER STANDARDS FOR CUSTOMIZED LIVING SERVICES IN DESIGNATED SETTINGS.**

The commissioner of human services shall review policies and provider standards for customized living services provided in settings identified in Minnesota Statutes, section 256S.20, subdivision 1, paragraph (a), clause (2), in consultation with stakeholders. The commissioner may provide recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over customized living services by February 15, 2022, regarding appropriate regulatory oversight and payment policies for customized living services delivered in these settings."

Page 573, after line 19, insert:

"(c) Minnesota Statutes 2020, section 256S.20, subdivision 2, is repealed effective August 1, 2021."

Page 774, line 12, delete "clinical" and after "of" insert "clinical"

Page 774, line 13, strike "mental health professional who is" and delete the second "a" and before "psychologist" insert "doctoral level" and strike "licensed for independent practice at"

Page 774, line 14, strike "the doctoral level" and before "psychiatrist" insert "board certified or board eligible" and strike "who is"

Page 774, line 15, delete the new language and after the period insert "These policies and procedures must be developed with the involvement of a doctoral level psychologist and a board certified or board eligible psychiatrist, and must include: "

Page 774, before line 17 insert:

"(1) requirements for when to seek clinical consultation by doctoral level psychologist or a board certified or board eligible psychiatrist;

(2) requirements for the involvement of a doctoral level psychologist or a board certified or board eligible psychiatrist in the direction of clinical services; and

(3) involvement of a doctoral level psychologist or a board certified or board eligible psychiatrist in quality improvement initiatives and review as part of a multidisciplinary care team."

Page 828, line 14, delete "9,104,766,000" and insert "9,104,404,000" and delete "9,590,833,000" and insert "9,590,575,000"

Page 828, line 17, delete "7,946,174,000" and insert "7,945,812,000" and delete "8,457,181,000" and insert "8,456,923,000"

Page 833, line 18, delete "175,265,000" and insert "175,025,000"

Page 835, line 8, delete "$162,308,000" and insert "$162,260,000"

Page 840, line 6, delete "6,058,378,000" and insert "6,058,256,000" and delete "6,557,536,000" and insert "6,577,278,000"

Page 847, lines 16 and 20, after "counties" insert "and tribal governments"

Page 847, line 25, after "expenses" insert "and $70,000 in fiscal year 2022 is available to the commissioner for the children's mental health residential treatment work group"

Page 850, line 17, delete "258,989,000" and insert "259,373,000"

Page 850, line 20, delete "155,953,000" and insert "156,337,000"

Page 853, line 9, after the period insert "A community health board or local unit of government must use any funds provided under this paragraph to supplement and not supplant local funds being used for public health purposes."

Page 855, line 34, delete "$110,895,000" and insert "$110,762,000"

Page 856, line 8, delete "30,686,000" and insert "31,070,000"

Page 856, line 27, delete "$500,000" and insert "$4,343,000"

Page 867, line 23, delete "$1,650,000" and insert "$1,435,000" and after "evaluation" insert "and equity report"

Page 867, line 24, delete "subdivision 3" and insert "subdivisions 3 and 4"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly