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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 2128

03/11/2021 Authored by Liebling and Schultz
The bill was read for the first time and referred to the Committee on Health Finance and Policy

1.1 A bill for an act
1.2 relating to health; modifying provisions governing health care, human services,
1.3 and licensing and background studies; establishing a budget for health and human
1.4 services; making technical and conforming changes; transferring money;
1.5 appropriating money; amending Minnesota Statutes 2020, sections 62J.495,
1.6 subdivisions 1, 2, 3, 4; 62J.498; 62J.4981; 62J.4982; 62V.05, by adding a
1.7 subdivision; 122A.18, subdivision 8; 144.1205, subdivisions 2, 4, 8, 9, by adding
1.8 a subdivision; 144.125, subdivision 1; 145.901; 174.30, subdivision 3; 245A.10,
1.9 subdivision 4; 245C.02, by adding subdivisions; 245C.03; 245C.05, subdivisions
1.10 1, 2, 2a, 2b, 4; 245C.08, by adding subdivisions; 245C.10, subdivision 15, by
1.11 adding subdivisions; 245C.13, subdivision 2; 245C.14, by adding a subdivision;
1.12 245C.16, subdivisions 1, 2; 245C.17, subdivision 1, by adding a subdivision;
1.13 245C.18; 256.9695, subdivision 1; 256.983; 256B.04, subdivisions 12, 14;
1.14 256B.057, subdivision 3; 256B.0622, subdivision 7a; 256B.0625, subdivisions
1.15 3b, 9, 13, 13e, 17, 17b, 18, 18b, 58; 256B.0947, subdivision 6; 256B.0949,
1.16 subdivision 13, by adding a subdivision; 256B.69, subdivision 6d; 256B.75;
1.17 256B.76, subdivisions 2, 4; 256B.766; 256B.767; 256B.79, subdivisions 1, 3;
1.18 256L.01, subdivision 5; 256L.04, subdivision 7b; 256L.05, subdivision 3a; 256L.11,
1.19 subdivision 7; 326.71, subdivision 4; 326.75, subdivisions 1, 2, 3; Laws 2017,
1.20 chapter 13, article 1, section 15, as amended; Laws 2019, First Special Session
1.21 chapter 9, article 14, section 3, as amended; proposing coding for new law in
1.22 Minnesota Statutes, chapters 145; 245C; 256B; repealing Minnesota Statutes 2020,
1.23 sections 245C.10, subdivisions 2, 2a, 3, 4, 5, 6, 7, 8, 9, 9a, 10, 11, 12, 13, 14, 16;
1.24 256B.0625, subdivisions 18c, 18d, 18e, 18h; 256L.11, subdivision 6a.

1.25 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.26 ARTICLE 1
1.27 HEALTH CARE

1.28 Section 1. Minnesota Statutes 2020, section 256.9695, subdivision 1, is amended to read:
1.29 Subdivision 1. Appeals. A hospital may appeal a decision arising from the application
1.30 of standards or methods under section 256.9685, 256.9686, or 256.969, if an appeal would
1.31 result in a change to the hospital's payment rate or payments. Both overpayments and

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

2.9 To appeal a payment rate or payment determination or a determination made from base  
 2.10 year information, the hospital shall file a written appeal request to the commissioner within  
 2.11 60 days of the date the preliminary payment rate determination was mailed. The appeal  
 2.12 request shall specify: (i) the disputed items; (ii) the authority in federal or state statute or  
 2.13 rule upon which the hospital relies for each disputed item; and (iii) the name and address  
 2.14 of the person to contact regarding the appeal. Facts to be considered in any appeal of base  
 2.15 year information are limited to those in existence ~~12~~ 18 months after the last day of the  
 2.16 calendar year that is the base year for the payment rates in dispute.

2.17 Sec. 2. Minnesota Statutes 2020, section 256B.057, subdivision 3, is amended to read:

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

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

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

2.29 (3) the person's assets are no more than (i) \$10,000 for a single individual, or (ii) \$18,000  
 2.30 for a married couple or family of two or more; or, when the resource limits for eligibility  
 2.31 for the Medicare Part D extra help low income subsidy (LIS) exceed either amount in item  
 2.32 (i) or (ii), the person's assets are no more than the LIS resource limit in United States Code,  
 2.33 title 42, section 1396d, subsection (p).

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

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

3.7 Sec. 3. Minnesota Statutes 2020, section 256B.0622, subdivision 7a, is amended to read:

3.8 Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)

3.9 The required treatment staff qualifications and roles for an ACT team are:

3.10 (1) the team leader:

3.11 (i) shall be a licensed mental health professional who is qualified under Minnesota Rules,  
3.12 part 9505.0371, subpart 5, item A. Individuals who are not licensed but who are eligible  
3.13 for licensure and are otherwise qualified may also fulfill this role but must obtain full  
3.14 licensure within 24 months of assuming the role of team leader;

3.15 (ii) must be an active member of the ACT team and provide some direct services to  
3.16 clients;

3.17 (iii) must be a single full-time staff member, dedicated to the ACT team, who is  
3.18 responsible for overseeing the administrative operations of the team, providing clinical  
3.19 oversight of services in conjunction with the psychiatrist or psychiatric care provider, and  
3.20 supervising team members to ensure delivery of best and ethical practices; and

3.21 (iv) must be available to provide overall clinical oversight to the ACT team after regular  
3.22 business hours and on weekends and holidays. The team leader may delegate this duty to  
3.23 another qualified member of the ACT team;

3.24 (2) the psychiatric care provider:

3.25 (i) must be a licensed psychiatrist certified by the American Board of Psychiatry and  
3.26 Neurology or eligible for board certification or certified by the American Osteopathic Board  
3.27 of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who  
3.28 is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A. The psychiatric care  
3.29 provider must have demonstrated clinical experience working with individuals with serious  
3.30 and persistent mental illness;

3.31 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for  
3.32 screening and admitting clients; monitoring clients' treatment and team member service

4.1 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,  
4.2 and health-related conditions; actively collaborating with nurses; and helping provide clinical  
4.3 supervision to the team;

4.4 (iii) shall fulfill the following functions for assertive community treatment clients:  
4.5 provide assessment and treatment of clients' symptoms and response to medications, including  
4.6 side effects; provide brief therapy to clients; provide diagnostic and medication education  
4.7 to clients, with medication decisions based on shared decision making; monitor clients'  
4.8 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and  
4.9 community visits;

4.10 (iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized  
4.11 for mental health treatment and shall communicate directly with the client's inpatient  
4.12 psychiatric care providers to ensure continuity of care;

4.13 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per  
4.14 50 clients. Part-time psychiatric care providers shall have designated hours to work on the  
4.15 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,  
4.16 supervisory, and administrative responsibilities. No more than two psychiatric care providers  
4.17 may share this role;

4.18 (vi) may ~~not provide specific roles and responsibilities by telemedicine unless approved~~  
4.19 ~~by the commissioner~~ provide services by telemedicine when necessary to ensure the  
4.20 continuation of psychiatric and medication services availability for clients and to maintain  
4.21 statutory requirements for psychiatric care provider staffing levels; and

4.22 (vii) shall provide psychiatric backup to the program after regular business hours and  
4.23 on weekends and holidays. The psychiatric care provider may delegate this duty to another  
4.24 qualified psychiatric provider;

4.25 (3) the nursing staff:

4.26 (i) shall consist of one to three registered nurses or advanced practice registered nurses,  
4.27 of whom at least one has a minimum of one-year experience working with adults with  
4.28 serious mental illness and a working knowledge of psychiatric medications. No more than  
4.29 two individuals can share a full-time equivalent position;

4.30 (ii) are responsible for managing medication, administering and documenting medication  
4.31 treatment, and managing a secure medication room; and

4.32 (iii) shall develop strategies, in collaboration with clients, to maximize taking medications  
4.33 as prescribed; screen and monitor clients' mental and physical health conditions and

5.1 medication side effects; engage in health promotion, prevention, and education activities;  
5.2 communicate and coordinate services with other medical providers; facilitate the development  
5.3 of the individual treatment plan for clients assigned; and educate the ACT team in monitoring  
5.4 psychiatric and physical health symptoms and medication side effects;

5.5 (4) the co-occurring disorder specialist:

5.6 (i) shall be a full-time equivalent co-occurring disorder specialist who has received  
5.7 specific training on co-occurring disorders that is consistent with national evidence-based  
5.8 practices. The training must include practical knowledge of common substances and how  
5.9 they affect mental illnesses, the ability to assess substance use disorders and the client's  
5.10 stage of treatment, motivational interviewing, and skills necessary to provide counseling to  
5.11 clients at all different stages of change and treatment. The co-occurring disorder specialist  
5.12 may also be an individual who is a licensed alcohol and drug counselor as described in  
5.13 section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience,  
5.14 and other requirements in section 245G.11, subdivision 5. No more than two co-occurring  
5.15 disorder specialists may occupy this role; and

5.16 (ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients.  
5.17 The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT  
5.18 team members on co-occurring disorders;

5.19 (5) the vocational specialist:

5.20 (i) shall be a full-time vocational specialist who has at least one-year experience providing  
5.21 employment services or advanced education that involved field training in vocational services  
5.22 to individuals with mental illness. An individual who does not meet these qualifications  
5.23 may also serve as the vocational specialist upon completing a training plan approved by the  
5.24 commissioner;

5.25 (ii) shall provide or facilitate the provision of vocational services to clients. The vocational  
5.26 specialist serves as a consultant and educator to fellow ACT team members on these services;  
5.27 and

5.28 (iii) should not refer individuals to receive any type of vocational services or linkage by  
5.29 providers outside of the ACT team;

5.30 (6) the mental health certified peer specialist:

5.31 (i) shall be a full-time equivalent mental health certified peer specialist as defined in  
5.32 section 256B.0615. No more than two individuals can share this position. The mental health  
5.33 certified peer specialist is a fully integrated team member who provides highly individualized

6.1 services in the community and promotes the self-determination and shared decision-making  
6.2 abilities of clients. This requirement may be waived due to workforce shortages upon  
6.3 approval of the commissioner;

6.4 (ii) must provide coaching, mentoring, and consultation to the clients to promote recovery,  
6.5 self-advocacy, and self-direction, promote wellness management strategies, and assist clients  
6.6 in developing advance directives; and

6.7 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage  
6.8 wellness and resilience, provide consultation to team members, promote a culture where  
6.9 the clients' points of view and preferences are recognized, understood, respected, and  
6.10 integrated into treatment, and serve in a manner equivalent to other team members;

6.11 (7) the program administrative assistant shall be a full-time office-based program  
6.12 administrative assistant position assigned to solely work with the ACT team, providing a  
6.13 range of supports to the team, clients, and families; and

6.14 (8) additional staff:

6.15 (i) shall be based on team size. Additional treatment team staff may include licensed  
6.16 mental health professionals as defined in Minnesota Rules, part 9505.0371, subpart 5, item  
6.17 A; mental health practitioners as defined in section 245.462, subdivision 17; a mental health  
6.18 practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371,  
6.19 subpart 5, item C; or mental health rehabilitation workers as defined in section 256B.0623,  
6.20 subdivision 5, paragraph (a), clause (4). These individuals shall have the knowledge, skills,  
6.21 and abilities required by the population served to carry out rehabilitation and support  
6.22 functions; and

6.23 (ii) shall be selected based on specific program needs or the population served.

6.24 (b) Each ACT team must clearly document schedules for all ACT team members.

6.25 (c) Each ACT team member must serve as a primary team member for clients assigned  
6.26 by the team leader and are responsible for facilitating the individual treatment plan process  
6.27 for those clients. The primary team member for a client is the responsible team member  
6.28 knowledgeable about the client's life and circumstances and writes the individual treatment  
6.29 plan. The primary team member provides individual supportive therapy or counseling, and  
6.30 provides primary support and education to the client's family and support system.

6.31 (d) Members of the ACT team must have strong clinical skills, professional qualifications,  
6.32 experience, and competency to provide a full breadth of rehabilitation services. Each staff  
6.33 member shall be proficient in their respective discipline and be able to work collaboratively

7.1 as a member of a multidisciplinary team to deliver the majority of the treatment,  
7.2 rehabilitation, and support services clients require to fully benefit from receiving assertive  
7.3 community treatment.

7.4 (e) Each ACT team member must fulfill training requirements established by the  
7.5 commissioner.

7.6 Sec. 4. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, is amended to read:

7.7 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary  
7.8 services and consultations delivered by a licensed health care provider via telemedicine in  
7.9 the same manner as if the service or consultation was delivered in person. ~~Coverage is~~  
7.10 ~~limited to three telemedicine services per enrollee per calendar week, except as provided~~  
7.11 ~~in paragraph (f).~~ Telemedicine services shall be paid at the full allowable rate.

7.12 (b) The commissioner shall establish criteria that a health care provider must attest to  
7.13 in order to demonstrate the safety or efficacy of delivering a particular service via  
7.14 telemedicine. The attestation may include that the health care provider:

7.15 (1) has identified the categories or types of services the health care provider will provide  
7.16 via telemedicine;

7.17 (2) has written policies and procedures specific to telemedicine services that are regularly  
7.18 reviewed and updated;

7.19 (3) has policies and procedures that adequately address patient safety before, during,  
7.20 and after the telemedicine service is rendered;

7.21 (4) has established protocols addressing how and when to discontinue telemedicine  
7.22 services; and

7.23 (5) has an established quality assurance process related to telemedicine services.

7.24 (c) As a condition of payment, a licensed health care provider must document each  
7.25 occurrence of a health service provided by telemedicine to a medical assistance enrollee.  
7.26 Health care service records for services provided by telemedicine must meet the requirements  
7.27 set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

7.28 (1) the type of service provided by telemedicine;

7.29 (2) the time the service began and the time the service ended, including an a.m. and p.m.  
7.30 designation;

8.1 (3) the licensed health care provider's basis for determining that telemedicine is an  
8.2 appropriate and effective means for delivering the service to the enrollee;

8.3 (4) the mode of transmission of the telemedicine service and records evidencing that a  
8.4 particular mode of transmission was utilized;

8.5 (5) the location of the originating site and the distant site;

8.6 (6) if the claim for payment is based on a physician's telemedicine consultation with  
8.7 another physician, the written opinion from the consulting physician providing the  
8.8 telemedicine consultation; and

8.9 (7) compliance with the criteria attested to by the health care provider in accordance  
8.10 with paragraph (b).

8.11 (d) For purposes of this subdivision, unless otherwise covered under this chapter,  
8.12 "telemedicine" is defined as the delivery of health care services or consultations while the  
8.13 patient is at an originating site, including the patient's home, and the licensed health care  
8.14 provider is at a distant site. A communication between licensed health care providers, or a  
8.15 licensed health care provider and a patient that consists solely of a telephone conversation,  
8.16 e-mail, or facsimile transmission does not constitute telemedicine consultations or services.  
8.17 Telemedicine may be provided by means of real-time two-way, interactive audio and visual  
8.18 communications, including the application of secure video conferencing or store-and-forward  
8.19 technology to provide or support health care delivery, which facilitate the assessment,  
8.20 diagnosis, consultation, treatment, education, and care management of a patient's health  
8.21 care.

8.22 (e) For purposes of this section, "licensed health care provider" means a licensed health  
8.23 care provider under section 62A.671, subdivision 6; a community paramedic as defined  
8.24 under section 144E.001, subdivision 5; ~~or~~; a mental health practitioner defined under section  
8.25 245.462, subdivision 17, or 245.4871, subdivision 26, ~~working under the general supervision~~  
8.26 ~~of a mental health professional, and~~; a community health worker who meets the criteria  
8.27 under subdivision 49, paragraph (a); a mental health certified peer specialist under section  
8.28 256B.0615, subdivision 5; a mental health certified family peer specialist under section  
8.29 256B.0616, subdivision 5; a mental health rehabilitation worker under section 256B.0623,  
8.30 subdivision 5, paragraph (a), clause (4), and paragraph (b); a mental health behavioral aide  
8.31 under section 256B.0943, subdivision 7, paragraph (b), clause (3); an alcohol and drug  
8.32 counselor under section 245G.11, subdivision 5; a treatment coordinator under section  
8.33 245G.11, subdivision 7; or a recovery peer under section 245G.11, subdivision 8; "health



9.1 care provider" is defined under section 62A.671, subdivision 3; and "originating site" is  
 9.2 defined under section 62A.671, subdivision 7.

9.3 ~~(f) The limit on coverage of three telemedicine services per enrollee per calendar week~~  
 9.4 ~~does not apply if:~~

9.5 ~~(1) the telemedicine services provided by the licensed health care provider are for the~~  
 9.6 ~~treatment and control of tuberculosis; and~~

9.7 ~~(2) the services are provided in a manner consistent with the recommendations and best~~  
 9.8 ~~practices specified by the Centers for Disease Control and Prevention and the commissioner~~  
 9.9 ~~of health.~~

9.10 (f) Telemedicine visits, as described in this section, can be used to satisfy the face-to-face  
 9.11 requirement for consideration of reimbursement under the payment methods that apply to  
 9.12 a federally qualified health center, rural health clinic, Indian health service, 638 tribal clinic,  
 9.13 and certified community behavioral health clinic, if the service would have otherwise  
 9.14 qualified for payment if performed in person.

9.15 **EFFECTIVE DATE.** This section is effective upon federal approval.

9.16 Sec. 5. Minnesota Statutes 2020, section 256B.0625, subdivision 13, is amended to read:

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

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

9.30 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical  
 9.31 ingredient" is defined as a substance that is represented for use in a drug and when used in  
 9.32 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the  
 9.33 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle

10.1 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and  
10.2 excipients which are included in the medical assistance formulary. Medical assistance covers  
10.3 selected active pharmaceutical ingredients and excipients used in compounded prescriptions  
10.4 when the compounded combination is specifically approved by the commissioner or when  
10.5 a commercially available product:

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

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

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

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

10.25 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable  
10.26 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and  
10.27 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible  
10.28 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and  
10.29 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these  
10.30 individuals, medical assistance may cover drugs from the drug classes listed in United States  
10.31 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to  
10.32 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall  
10.33 not be covered.

11.1 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing  
11.2 Program and dispensed by 340B covered entities and ambulatory pharmacies under common  
11.3 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired  
11.4 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

11.5 (g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal  
11.6 contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section  
11.7 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a  
11.8 licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists  
11.9 used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed  
11.10 pharmacist in accordance with section 151.37, subdivision 16.

11.11 Sec. 6. Minnesota Statutes 2020, section 256B.0625, subdivision 13e, is amended to read:

11.12 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall  
11.13 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the  
11.14 usual and customary price charged to the public. The usual and customary price means the  
11.15 lowest price charged by the provider to a patient who pays for the prescription by cash,  
11.16 check, or charge account and includes prices the pharmacy charges to a patient enrolled in  
11.17 a prescription savings club or prescription discount club administered by the pharmacy or  
11.18 pharmacy chain. The amount of payment basis must be reduced to reflect all discount  
11.19 amounts applied to the charge by any third-party provider/insurer agreement or contract for  
11.20 submitted charges to medical assistance programs. The net submitted charge may not be  
11.21 greater than the patient liability for the service. The professional dispensing fee shall be  
11.22 ~~\$10.48~~ \$9.91 for prescriptions filled with legend drugs meeting the definition of "covered  
11.23 outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The  
11.24 dispensing fee for intravenous solutions that must be compounded by the pharmacist shall  
11.25 be ~~\$10.48~~ \$9.91 per ~~bag~~ claim. The professional dispensing fee for prescriptions filled with  
11.26 over-the-counter drugs meeting the definition of covered outpatient drugs shall be ~~\$10.48~~  
11.27 \$9.91 for dispensed quantities equal to or greater than the number of units contained in the  
11.28 manufacturer's original package. The professional dispensing fee shall be prorated based  
11.29 on the percentage of the package dispensed when the pharmacy dispenses a quantity less  
11.30 than the number of units contained in the manufacturer's original package. The pharmacy  
11.31 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered  
11.32 outpatient drugs shall be \$3.65 for quantities equal to or greater than the number of units  
11.33 contained in the manufacturer's original package and shall be prorated based on the  
11.34 percentage of the package dispensed when the pharmacy dispenses a quantity less than the  
11.35 number of units contained in the manufacturer's original package. The National Average

12.1 Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug.  
12.2 For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient  
12.3 cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for  
12.4 a provider participating in the federal 340B Drug Pricing Program shall be either the 340B  
12.5 Drug Pricing Program ceiling price established by the Health Resources and Services  
12.6 Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as  
12.7 the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in  
12.8 the United States, not including prompt pay or other discounts, rebates, or reductions in  
12.9 price, for the most recent month for which information is available, as reported in wholesale  
12.10 price guides or other publications of drug or biological pricing data. The maximum allowable  
12.11 cost of a multisource drug may be set by the commissioner and it shall be comparable to  
12.12 the actual acquisition cost of the drug product and no higher than the NADAC of the generic  
12.13 product. Establishment of the amount of payment for drugs shall not be subject to the  
12.14 requirements of the Administrative Procedure Act.

12.15 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using  
12.16 an automated drug distribution system meeting the requirements of section 151.58, or a  
12.17 packaging system meeting the packaging standards set forth in Minnesota Rules, part  
12.18 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ  
12.19 retrospective billing for prescription drugs dispensed to long-term care facility residents. A  
12.20 retrospectively billing pharmacy must submit a claim only for the quantity of medication  
12.21 used by the enrolled recipient during the defined billing period. A retrospectively billing  
12.22 pharmacy must use a billing period not less than one calendar month or 30 days.

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

12.28 (d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC  
12.29 of the generic product or the maximum allowable cost established by the commissioner  
12.30 unless prior authorization for the brand name product has been granted according to the  
12.31 criteria established by the Drug Formulary Committee as required by subdivision 13f,  
12.32 paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in  
12.33 a manner consistent with section 151.21, subdivision 2.

12.34 (e) The basis for determining the amount of payment for drugs administered in an  
12.35 outpatient setting shall be the lower of the usual and customary cost submitted by the

13.1 provider, 106 percent of the average sales price as determined by the United States  
13.2 Department of Health and Human Services pursuant to title XVIII, section 1847a of the  
13.3 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost  
13.4 set by the commissioner. If average sales price is unavailable, the amount of payment must  
13.5 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition  
13.6 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.  
13.7 The commissioner shall discount the payment rate for drugs obtained through the federal  
13.8 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an  
13.9 outpatient setting shall be made to the administering facility or practitioner. A retail or  
13.10 specialty pharmacy dispensing a drug for administration in an outpatient setting is not  
13.11 eligible for direct reimbursement.

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

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

13.32 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey  
13.33 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient  
13.34 drugs under medical assistance. The commissioner shall ensure that the vendor has prior  
13.35 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the

14.1 department to dispense outpatient prescription drugs to fee-for-service members must  
14.2 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under  
14.3 section 256B.064 for failure to respond. The commissioner shall require the vendor to  
14.4 measure a single statewide cost of dispensing for all responding pharmacies to measure the  
14.5 mean, mean weighted by total prescription volume, mean weighted by medical assistance  
14.6 prescription volume, median, median weighted by total prescription volume, and median  
14.7 weighted by total medical assistance prescription volume. The commissioner shall post a  
14.8 copy of the final cost of dispensing survey report on the department's website. The initial  
14.9 survey must be completed no later than January 1, 2021, and repeated every three years.  
14.10 The commissioner shall provide a summary of the results of each cost of dispensing survey  
14.11 and provide recommendations for any changes to the dispensing fee to the chairs and ranking  
14.12 members of the legislative committees with jurisdiction over medical assistance pharmacy  
14.13 reimbursement.

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

14.17 Sec. 7. Minnesota Statutes 2020, section 256B.0625, subdivision 18, is amended to read:

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

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

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

15.1 Sec. 8. Minnesota Statutes 2020, section 256B.0625, subdivision 58, is amended to read:

15.2 Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** (a) Medical  
15.3 assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT).  
15.4 The payment amount for a complete EPSDT screening shall not include charges for health  
15.5 care services and products that are available at no cost to the provider and shall not exceed  
15.6 the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

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

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

15.17 Sec. 9. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

15.18 Subd. 6. **Service standards.** The standards in this subdivision apply to intensive  
15.19 nonresidential rehabilitative mental health services.

15.20 (a) The treatment team must use team treatment, not an individual treatment model.

15.21 (b) Services must be available at times that meet client needs.

15.22 (c) Services must be age-appropriate and meet the specific needs of the client.

15.23 (d) The initial functional assessment must be completed within ten days of intake and  
15.24 updated at least every six months or prior to discharge from the service, whichever comes  
15.25 first.

15.26 (e) An individual treatment plan must:

15.27 (1) be based on the information in the client's diagnostic assessment and baselines;

15.28 (2) identify goals and objectives of treatment, a treatment strategy, a schedule for  
15.29 accomplishing treatment goals and objectives, and the individuals responsible for providing  
15.30 treatment services and supports;

16.1 (3) be developed after completion of the client's diagnostic assessment by a mental health  
16.2 professional or clinical trainee and before the provision of children's therapeutic services  
16.3 and supports;

16.4 (4) be developed through a child-centered, family-driven, culturally appropriate planning  
16.5 process, including allowing parents and guardians to observe or participate in individual  
16.6 and family treatment services, assessments, and treatment planning;

16.7 (5) be reviewed at least once every six months and revised to document treatment progress  
16.8 on each treatment objective and next goals or, if progress is not documented, to document  
16.9 changes in treatment;

16.10 (6) be signed by the clinical supervisor and by the client or by the client's parent or other  
16.11 person authorized by statute to consent to mental health services for the client. A client's  
16.12 parent may approve the client's individual treatment plan by secure electronic signature or  
16.13 by documented oral approval that is later verified by written signature;

16.14 (7) be completed in consultation with the client's current therapist and key providers and  
16.15 provide for ongoing consultation with the client's current therapist to ensure therapeutic  
16.16 continuity and to facilitate the client's return to the community. For clients under the age of  
16.17 18, the treatment team must consult with parents and guardians in developing the treatment  
16.18 plan;

16.19 (8) if a need for substance use disorder treatment is indicated by validated assessment:

16.20 (i) identify goals, objectives, and strategies of substance use disorder treatment; develop  
16.21 a schedule for accomplishing treatment goals and objectives; and identify the individuals  
16.22 responsible for providing treatment services and supports;

16.23 (ii) be reviewed at least once every 90 days and revised, if necessary;

16.24 (9) be signed by the clinical supervisor and by the client and, if the client is a minor, by  
16.25 the client's parent or other person authorized by statute to consent to mental health treatment  
16.26 and substance use disorder treatment for the client; and

16.27 (10) provide for the client's transition out of intensive nonresidential rehabilitative mental  
16.28 health services by defining the team's actions to assist the client and subsequent providers  
16.29 in the transition to less intensive or "stepped down" services.

16.30 (f) The treatment team shall actively and assertively engage the client's family members  
16.31 and significant others by establishing communication and collaboration with the family and  
16.32 significant others and educating the family and significant others about the client's mental  
16.33 illness, symptom management, and the family's role in treatment, unless the team knows or



17.1 has reason to suspect that the client has suffered or faces a threat of suffering any physical  
17.2 or mental injury, abuse, or neglect from a family member or significant other.

17.3 (g) For a client age 18 or older, the treatment team may disclose to a family member,  
17.4 other relative, or a close personal friend of the client, or other person identified by the client,  
17.5 the protected health information directly relevant to such person's involvement with the  
17.6 client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the  
17.7 client is present, the treatment team shall obtain the client's agreement, provide the client  
17.8 with an opportunity to object, or reasonably infer from the circumstances, based on the  
17.9 exercise of professional judgment, that the client does not object. If the client is not present  
17.10 or is unable, by incapacity or emergency circumstances, to agree or object, the treatment  
17.11 team may, in the exercise of professional judgment, determine whether the disclosure is in  
17.12 the best interests of the client and, if so, disclose only the protected health information that  
17.13 is directly relevant to the family member's, relative's, friend's, or client-identified person's  
17.14 involvement with the client's health care. The client may orally agree or object to the  
17.15 disclosure and may prohibit or restrict disclosure to specific individuals.

17.16 (h) The treatment team shall provide interventions to promote positive interpersonal  
17.17 relationships.

17.18 (i) The services and responsibilities of the psychiatric provider may be provided through  
17.19 telemedicine when necessary to prevent disruption in client services or to maintain the  
17.20 required psychiatric staffing level.

17.21 Sec. 10. Minnesota Statutes 2020, section 256B.0949, subdivision 13, is amended to read:

17.22 Subd. 13. **Covered services.** (a) The services described in paragraphs (b) to (l) are  
17.23 eligible for reimbursement by medical assistance under this section. Services must be  
17.24 provided by a qualified EIDBI provider and supervised by a QSP. An EIDBI service must  
17.25 address the person's medically necessary treatment goals and must be targeted to develop,  
17.26 enhance, or maintain the individual developmental skills of a person with ASD or a related  
17.27 condition to improve functional communication, including nonverbal or social  
17.28 communication, social or interpersonal interaction, restrictive or repetitive behaviors,  
17.29 hyperreactivity or hyporeactivity to sensory input, behavioral challenges and self-regulation,  
17.30 cognition, learning and play, self-care, and safety.

17.31 (b) EIDBI treatment must be delivered consistent with the standards of an approved  
17.32 modality, as published by the commissioner. EIDBI modalities include:

17.33 (1) applied behavior analysis (ABA);

18.1 (2) developmental individual-difference relationship-based model (DIR/Floortime);

18.2 (3) early start Denver model (ESDM);

18.3 (4) PLAY project;

18.4 (5) relationship development intervention (RDI); or

18.5 (6) additional modalities not listed in clauses (1) to (5) upon approval by the  
18.6 commissioner.

18.7 (c) An EIDBI provider may use one or more of the EIDBI modalities in paragraph (b),  
18.8 clauses (1) to (5), as the primary modality for treatment as a covered service, or several  
18.9 EIDBI modalities in combination as the primary modality of treatment, as approved by the  
18.10 commissioner. An EIDBI provider that identifies and provides assurance of qualifications  
18.11 for a single specific treatment modality must document the required qualifications to meet  
18.12 fidelity to the specific model.

18.13 (d) Each qualified EIDBI provider must identify and provide assurance of qualifications  
18.14 for professional licensure certification, or training in evidence-based treatment methods,  
18.15 and must document the required qualifications outlined in subdivision 15 in a manner  
18.16 determined by the commissioner.

18.17 (e) CMDE is a comprehensive evaluation of the person's developmental status to  
18.18 determine medical necessity for EIDBI services and meets the requirements of subdivision  
18.19 5. The services must be provided by a qualified CMDE provider.

18.20 (f) EIDBI intervention observation and direction is the clinical direction and oversight  
18.21 of EIDBI services by the QSP, level I treatment provider, or level II treatment provider,  
18.22 including developmental and behavioral techniques, progress measurement, data collection,  
18.23 function of behaviors, and generalization of acquired skills for the direct benefit of a person.  
18.24 EIDBI intervention observation and direction informs any modification of the current  
18.25 treatment protocol to support the outcomes outlined in the ITP.

18.26 (g) Intervention is medically necessary direct treatment provided to a person with ASD  
18.27 or a related condition as outlined in their ITP. All intervention services must be provided  
18.28 under the direction of a QSP. Intervention may take place across multiple settings. The  
18.29 frequency and intensity of intervention services are provided based on the number of  
18.30 treatment goals, person and family or caregiver preferences, and other factors. Intervention  
18.31 services may be provided individually or in a group. Intervention with a higher provider  
18.32 ratio may occur when deemed medically necessary through the person's ITP.

19.1 (1) Individual intervention is treatment by protocol administered by a single qualified  
 19.2 EIDBI provider delivered ~~face-to-face~~ to one person.

19.3 (2) Group intervention is treatment by protocol provided by one or more qualified EIDBI  
 19.4 providers, delivered to at least two people who receive EIDBI services.

19.5 (h) ITP development and ITP progress monitoring is development of the initial, annual,  
 19.6 and progress monitoring of an ITP. ITP development and ITP progress monitoring documents  
 19.7 provide oversight and ongoing evaluation of a person's treatment and progress on targeted  
 19.8 goals and objectives and integrate and coordinate the person's and the person's legal  
 19.9 representative's information from the CMDE and ITP progress monitoring. This service  
 19.10 must be reviewed and completed by the QSP, and may include input from a level I provider  
 19.11 or a level II provider.

19.12 (i) Family caregiver training and counseling is specialized training and education for a  
 19.13 family or primary caregiver to understand the person's developmental status and help with  
 19.14 the person's needs and development. This service must be provided by the QSP, level I  
 19.15 provider, or level II provider.

19.16 (j) A coordinated care conference is a voluntary ~~face-to-face~~ meeting with the person  
 19.17 and the person's family to review the CMDE or ITP progress monitoring and to integrate  
 19.18 and coordinate services across providers and service-delivery systems to develop the ITP.  
 19.19 This service must be provided by the QSP and may include the CMDE provider or a level  
 19.20 I provider or a level II provider.

19.21 (k) Travel time is allowable billing for traveling to and from the person's home, school,  
 19.22 a community setting, or place of service outside of an EIDBI center, clinic, or office from  
 19.23 a specified location to provide ~~face-to-face~~ in-person EIDBI intervention, observation and  
 19.24 direction, or family caregiver training and counseling. The person's ITP must specify the  
 19.25 reasons the provider must travel to the person.

19.26 (l) Medical assistance covers medically necessary EIDBI services and consultations  
 19.27 delivered by a licensed health care provider via telemedicine, as defined under section  
 19.28 256B.0625, subdivision 3b, in the same manner as if the service or consultation was delivered  
 19.29 in person.

19.30 Sec. 11. Minnesota Statutes 2020, section 256B.75, is amended to read:

19.31 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

19.32 (a) For outpatient hospital facility fee payments for services rendered on or after October  
 19.33 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,

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

20.14 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory  
20.15 surgery hospital facility fee services for critical access hospitals designated under section  
20.16 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the  
20.17 cost-finding methods and allowable costs of the Medicare program. Effective for services  
20.18 provided on or after July 1, 2015, rates established for critical access hospitals under this  
20.19 paragraph for the applicable payment year shall be the final payment and shall not be settled  
20.20 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal  
20.21 year ending in 2017, the rate for outpatient hospital services shall be computed using  
20.22 information from each hospital's Medicare cost report as filed with Medicare for the year  
20.23 that is two years before the year that the rate is being computed. Rates shall be computed  
20.24 using information from Worksheet C series until the department finalizes the medical  
20.25 assistance cost reporting process for critical access hospitals. After the cost reporting process  
20.26 is finalized, rates shall be computed using information from Title XIX Worksheet D series.  
20.27 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs  
20.28 related to rural health clinics and federally qualified health clinics, divided by ancillary  
20.29 charges plus outpatient charges, excluding charges related to rural health clinics and federally  
20.30 qualified health clinics.

20.31 (c) Effective for services provided on or after July 1, 2003, rates that are based on the  
20.32 Medicare outpatient prospective payment system shall be replaced by a budget neutral  
20.33 prospective payment system that is derived using medical assistance data. The commissioner  
20.34 shall provide a proposal to the 2003 legislature to define and implement this provision.  
20.35 When implementing prospective payment methodologies, the commissioner shall use general

21.1 methods and rate calculation parameters similar to the applicable Medicare prospective  
 21.2 payment systems for services delivered in outpatient hospital and ambulatory surgical center  
 21.3 settings unless other payment methodologies for these services are specified in this chapter.

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

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

21.12 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for  
 21.13 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient  
 21.14 hospital facility services before third-party liability and spenddown, is reduced three percent  
 21.15 from the current statutory rates. Mental health services and facilities defined under section  
 21.16 256.969, subdivision 16, are excluded from this paragraph.

21.17 Sec. 12. Minnesota Statutes 2020, section 256B.79, subdivision 1, is amended to read:

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

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

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

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

22.1 Sec. 13. Minnesota Statutes 2020, section 256B.79, subdivision 3, is amended to read:

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

22.13 Sec. 14. Minnesota Statutes 2020, section 256L.01, subdivision 5, is amended to read:

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

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

22.19 Sec. 15. Minnesota Statutes 2020, section 256L.04, subdivision 7b, is amended to read:

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

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

22.24 Sec. 16. Minnesota Statutes 2020, section 256L.05, subdivision 3a, is amended to read:

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

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

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

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

## 23.6 ARTICLE 2

### 23.7 LICENSING AND BACKGROUND STUDIES

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

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

23.12 (1) each navigator;

23.13 (2) each in-person assister; and

23.14 (3) each certified application counselor.

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

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

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

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

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

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

23.28 Subd. 8. **Background checks studies.** (a) The Professional Educator Licensing and  
 23.29 Standards Board and the Board of School Administrators must ~~obtain a~~ initiate criminal

24.1 history background ~~check on~~ studies of all first-time ~~teaching~~ applicants for educator licenses  
 24.2 under their jurisdiction. Applicants must include with their licensure applications:

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

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

24.9 (b) The background check for all first-time teaching applicants for licenses must include  
 24.10 a review of information from the Bureau of Criminal Apprehension, including criminal  
 24.11 history data as defined in section 13.87, and must also include a review of the national  
 24.12 criminal records repository. The superintendent of the Bureau of Criminal Apprehension  
 24.13 is authorized to exchange fingerprints with the Federal Bureau of Investigation for purposes  
 24.14 of the criminal history check. The superintendent shall recover the cost to the bureau of a  
 24.15 background check through the fee charged to the applicant under paragraph (a).

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

24.20 Sec. 3. Minnesota Statutes 2020, section 245A.10, subdivision 4, is amended to read:

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

| 24.23 | Licensed Capacity   | Child Care Center |
|-------|---------------------|-------------------|
| 24.24 |                     | License Fee       |
| 24.25 | 1 to 24 persons     | \$200             |
| 24.26 | 25 to 49 persons    | \$300             |
| 24.27 | 50 to 74 persons    | \$400             |
| 24.28 | 75 to 99 persons    | \$500             |
| 24.29 | 100 to 124 persons  | \$600             |
| 24.30 | 125 to 149 persons  | \$700             |
| 24.31 | 150 to 174 persons  | \$800             |
| 24.32 | 175 to 199 persons  | \$900             |
| 24.33 | 200 to 224 persons  | \$1,000           |
| 24.34 | 225 or more persons | \$1,100           |



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

| 25.7  | License Holder Annual Revenue             | License Fee |
|-------|---|-------------|
| 25.8  | less than or equal to \$10,000            | \$200       |
| 25.9  | greater than \$10,000 but less than or    |             |
| 25.10 | equal to \$25,000                         | \$300       |
| 25.11 | greater than \$25,000 but less than or    |             |
| 25.12 | equal to \$50,000                         | \$400       |
| 25.13 | greater than \$50,000 but less than or    |             |
| 25.14 | equal to \$100,000                        | \$500       |
| 25.15 | greater than \$100,000 but less than or   |             |
| 25.16 | equal to \$150,000                        | \$600       |
| 25.17 | greater than \$150,000 but less than or   |             |
| 25.18 | equal to \$200,000                        | \$800       |
| 25.19 | greater than \$200,000 but less than or   |             |
| 25.20 | equal to \$250,000                        | \$1,000     |
| 25.21 | greater than \$250,000 but less than or   |             |
| 25.22 | equal to \$300,000                        | \$1,200     |
| 25.23 | greater than \$300,000 but less than or   |             |
| 25.24 | equal to \$350,000                        | \$1,400     |
| 25.25 | greater than \$350,000 but less than or   |             |
| 25.26 | equal to \$400,000                        | \$1,600     |
| 25.27 | greater than \$400,000 but less than or   |             |
| 25.28 | equal to \$450,000                        | \$1,800     |
| 25.29 | greater than \$450,000 but less than or   |             |
| 25.30 | equal to \$500,000                        | \$2,000     |
| 25.31 | greater than \$500,000 but less than or   |             |
| 25.32 | equal to \$600,000                        | \$2,250     |
| 25.33 | greater than \$600,000 but less than or   |             |
| 25.34 | equal to \$700,000                        | \$2,500     |
| 25.35 | greater than \$700,000 but less than or   |             |
| 25.36 | equal to \$800,000                        | \$2,750     |
| 25.37 | greater than \$800,000 but less than or   |             |
| 25.38 | equal to \$900,000                        | \$3,000     |
| 25.39 | greater than \$900,000 but less than or   |             |
| 25.40 | equal to \$1,000,000                      | \$3,250     |
| 25.41 | greater than \$1,000,000 but less than or |             |
| 25.42 | equal to \$1,250,000                      | \$3,500     |

|       |  |          |
|-------|--|----------|
| 26.1  | greater than \$1,250,000 but less than or  |          |
| 26.2  | equal to \$1,500,000                       | \$3,750  |
| 26.3  | greater than \$1,500,000 but less than or  |          |
| 26.4  | equal to \$1,750,000                       | \$4,000  |
| 26.5  | greater than \$1,750,000 but less than or  |          |
| 26.6  | equal to \$2,000,000                       | \$4,250  |
| 26.7  | greater than \$2,000,000 but less than or  |          |
| 26.8  | equal to \$2,500,000                       | \$4,500  |
| 26.9  | greater than \$2,500,000 but less than or  |          |
| 26.10 | equal to \$3,000,000                       | \$4,750  |
| 26.11 | greater than \$3,000,000 but less than or  |          |
| 26.12 | equal to \$3,500,000                       | \$5,000  |
| 26.13 | greater than \$3,500,000 but less than or  |          |
| 26.14 | equal to \$4,000,000                       | \$5,500  |
| 26.15 | greater than \$4,000,000 but less than or  |          |
| 26.16 | equal to \$4,500,000                       | \$6,000  |
| 26.17 | greater than \$4,500,000 but less than or  |          |
| 26.18 | equal to \$5,000,000                       | \$6,500  |
| 26.19 | greater than \$5,000,000 but less than or  |          |
| 26.20 | equal to \$7,500,000                       | \$7,000  |
| 26.21 | greater than \$7,500,000 but less than or  |          |
| 26.22 | equal to \$10,000,000                      | \$8,500  |
| 26.23 | greater than \$10,000,000 but less than or |          |
| 26.24 | equal to \$12,500,000                      | \$10,000 |
| 26.25 | greater than \$12,500,000 but less than or |          |
| 26.26 | equal to \$15,000,000                      | \$14,000 |
| 26.27 | greater than \$15,000,000                  | \$18,000 |

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

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

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

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

27.1 2017 and thereafter, the license holder shall pay an annual license fee according to clause  
27.2 (1).

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

| 27.6  | Licensed Capacity   | License Fee |
|-------|---------------------|-------------|
| 27.7  | 1 to 24 persons     | \$600       |
| 27.8  | 25 to 49 persons    | \$800       |
| 27.9  | 50 to 74 persons    | \$1,000     |
| 27.10 | 75 to 99 persons    | \$1,200     |
| 27.11 | 100 or more persons | \$1,400     |

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

| 27.16 | Licensed Capacity  | License Fee |
|-------|--------------------|-------------|
| 27.17 | 1 to 24 persons    | \$760       |
| 27.18 | 25 to 49 persons   | \$960       |
| 27.19 | 50 or more persons | \$1,160     |

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

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

| 27.26 | Licensed Capacity   | License Fee |
|-------|---------------------|-------------|
| 27.27 | 1 to 24 persons     | \$1,000     |
| 27.28 | 25 to 49 persons    | \$1,100     |
| 27.29 | 50 to 74 persons    | \$1,200     |
| 27.30 | 75 to 99 persons    | \$1,300     |
| 27.31 | 100 or more persons | \$1,400     |

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

|      | Licensed Capacity  | License Fee |
|------|--------------------|-------------|
| 28.1 |                    |             |
| 28.2 | 1 to 24 persons    | \$2,525     |
| 28.3 | 25 or more persons | \$2,725     |

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

|       | Licensed Capacity   | License Fee |
|-------|---------------------|-------------|
| 28.7  |                     |             |
| 28.8  | 1 to 24 persons     | \$450       |
| 28.9  | 25 to 49 persons    | \$650       |
| 28.10 | 50 to 74 persons    | \$850       |
| 28.11 | 75 to 99 persons    | \$1,050     |
| 28.12 | 100 or more persons | \$1,250     |

28.13 (h) A program licensed to provide independent living assistance for youth under section  
 28.14 245A.22 shall pay an annual nonrefundable license fee of \$1,500.

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

28.17 (j) A program licensed as an adult day care center licensed under Minnesota Rules, parts  
 28.18 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the  
 28.19 following schedule:

|       | Licensed Capacity   | License Fee |
|-------|---------------------|-------------|
| 28.20 |                     |             |
| 28.21 | 1 to 24 persons     | \$500       |
| 28.22 | 25 to 49 persons    | \$700       |
| 28.23 | 50 to 74 persons    | \$900       |
| 28.24 | 75 to 99 persons    | \$1,100     |
| 28.25 | 100 or more persons | \$1,300     |

28.26 (k) A program licensed to provide treatment services to persons with sexual psychopathic  
 28.27 personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to  
 28.28 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

28.29 (l) A mental health center or mental health clinic requesting certification for purposes  
 28.30 of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750  
 28.31 to 9520.0870, shall pay a certification fee of \$1,550 per year. If the mental health center or  
 28.32 mental health clinic provides services at a primary location with satellite facilities, the  
 28.33 satellite facilities shall be certified with the primary location without an additional charge.

29.1 Sec. 4. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision to  
29.2 read:

29.3 Subd. 5b. **Alternative background study.** "Alternative background study" means a  
29.4 review of records conducted by the commissioner pursuant to section 245C.08 in order to  
29.5 forward the background study investigating information to the entity that submitted the  
29.6 alternative background study request under section 245C.031, subdivision 2. The  
29.7 commissioner shall not make any eligibility determinations on background studies conducted  
29.8 under section 245C.031.

29.9 Sec. 5. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision to  
29.10 read:

29.11 Subd. 11c. **Entity.** "Entity" means any program or organization initiating a background  
29.12 study.

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

29.15 Subd. 16a. **Results.** "Results" means a determination that a study subject is eligible,  
29.16 disqualified, set aside, granted a variance, or that more time is needed to complete the  
29.17 background study.

29.18 Sec. 7. Minnesota Statutes 2020, section 245C.03, is amended to read:

29.19 **245C.03 BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.**

29.20 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background  
29.21 study on:

29.22 (1) the person or persons applying for a license;

29.23 (2) an individual age 13 and over living in the household where the licensed program  
29.24 will be provided who is not receiving licensed services from the program;

29.25 (3) current or prospective employees or contractors of the applicant who will have direct  
29.26 contact with persons served by the facility, agency, or program;

29.27 (4) volunteers or student volunteers who will have direct contact with persons served  
29.28 by the program to provide program services if the contact is not under the continuous, direct  
29.29 supervision by an individual listed in clause (1) or (3);

30.1 (5) an individual age ten to 12 living in the household where the licensed services will  
30.2 be provided when the commissioner has reasonable cause as defined in section 245C.02,  
30.3 subdivision 15;

30.4 (6) an individual who, without providing direct contact services at a licensed program,  
30.5 may have unsupervised access to children or vulnerable adults receiving services from a  
30.6 program, when the commissioner has reasonable cause as defined in section 245C.02,  
30.7 subdivision 15;

30.8 (7) all controlling individuals as defined in section 245A.02, subdivision 5a;

30.9 (8) notwithstanding the other requirements in this subdivision, child care background  
30.10 study subjects as defined in section 245C.02, subdivision 6a; and

30.11 (9) notwithstanding clause (3), for children's residential facilities and foster residence  
30.12 settings, any adult working in the facility, whether or not the individual will have direct  
30.13 contact with persons served by the facility.

30.14 (b) For child foster care when the license holder resides in the home where foster care  
30.15 services are provided, a short-term substitute caregiver providing direct contact services for  
30.16 a child for less than 72 hours of continuous care is not required to receive a background  
30.17 study under this chapter.

30.18 Subd. 1a. **Procedure.** (a) Individuals and organizations that are required under this  
30.19 section to have or initiate background studies shall comply with the requirements of this  
30.20 chapter.

30.21 (b) All studies conducted under this section shall be conducted according to sections  
30.22 299C.60 to 299C.64. This requirement does not apply to subdivisions 1, 4, 6a, 9, and 9a.

30.23 **Subd. 2. Personal care provider organizations.** The commissioner shall conduct  
30.24 background studies on any individual required under sections 256B.0651 to 256B.0654 and  
30.25 256B.0659 to have a background study completed under this chapter.

30.26 **Subd. 3. Supplemental nursing services agencies.** The commissioner shall conduct all  
30.27 background studies required under this chapter and initiated by supplemental nursing services  
30.28 agencies registered under section 144A.71, subdivision 1.

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

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

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

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

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

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

31.11 **Subd. 3b. Personal care assistance provider agency; background studies.** Personal  
 31.12 care assistance provider agencies enrolled to provide personal care assistance services under  
 31.13 the medical assistance program must meet the following requirements:

31.14 (1) owners who have a five percent interest or more and all managing employees are  
 31.15 subject to a background study as provided in this chapter. This requirement applies to  
 31.16 currently enrolled personal care assistance provider agencies and agencies seeking enrollment  
 31.17 as a personal care assistance provider agency. "Managing employee" has the same meaning  
 31.18 as Code of Federal Regulations, title 42, section 455. An organization is barred from  
 31.19 enrollment if:

31.20 (i) the organization has not initiated background studies of owners and managing  
 31.21 employees; or

31.22 (ii) the organization has initiated background studies of owners and managing employees  
 31.23 and the commissioner has sent the organization a notice that an owner or managing employee  
 31.24 of the organization has been disqualified under section 245C.14, and the owner or managing  
 31.25 employee has not received a set aside of the disqualification under section 245C.22; and

31.26 (2) a background study must be initiated and completed for all qualified professionals.

31.27 **Subd. 4. Personnel agencies; educational programs; professional services**  
 31.28 **agencies.** The commissioner also may conduct studies on individuals specified in subdivision  
 31.29 1, paragraph (a), clauses (3) and (4), when the studies are initiated by:

31.30 (1) personnel pool agencies;

31.31 (2) temporary personnel agencies;

32.1 (3) educational programs that train individuals by providing direct contact services in  
32.2 licensed programs; and

32.3 (4) professional services agencies that are not licensed and which contract with licensed  
32.4 programs to provide direct contact services or individuals who provide direct contact services.

32.5 Subd. 5. **Other state agencies.** The commissioner shall conduct background studies on  
32.6 applicants and license holders under the jurisdiction of other state agencies who are required  
32.7 in other statutory sections to initiate background studies under this chapter, including the  
32.8 applicant's or license holder's employees, contractors, and volunteers when required under  
32.9 other statutory sections.

32.10 Subd. 5a. **Facilities serving children or adults licensed or regulated by the**  
32.11 **Department of Health.** (a) The commissioner of health shall contract with the commissioner  
32.12 of human services to conduct background studies of:

32.13 (1) individuals providing services who have direct contact, as defined under section  
32.14 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes,  
32.15 outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and  
32.16 home care agencies licensed under chapter 144A; assisted living facilities and assisted living  
32.17 facilities with dementia care licensed under chapter 144G; and board and lodging  
32.18 establishments that are registered to provide supportive or health supervision services under  
32.19 section 157.17;

32.20 (2) individuals specified in section 245C.03, subdivision 1, who provide direct contact  
32.21 services in a nursing home or a home care agency licensed under chapter 144A; an assisted  
32.22 living facility or assisted living facility with dementia care licensed under chapter 144G;  
32.23 or a boarding care home licensed under sections 144.50 to 144.58. If the individual  
32.24 understudy resides outside of Minnesota, the study must include a check for substantiated  
32.25 findings of maltreatment of adults and children in the individual's state of residence when  
32.26 the state makes the information available;

32.27 (3) all other employees in assisted living facilities or assisted living facilities with  
32.28 dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A,  
32.29 and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of  
32.30 an individual in this section shall disqualify the individual from positions allowing direct  
32.31 contact with or access to patients or residents receiving services. "Access" means physical  
32.32 access to a client or the client's personal property without continuous, direct supervision as  
32.33 defined in section 245C.02, subdivision 8, when the employee's employment responsibilities  
32.34 do not include providing direct contact services;



33.1 (4) individuals employed by a supplemental nursing services agency, as defined under  
33.2 section 144A.70, who are providing services in health care facilities; and

33.3 (5) controlling persons of a supplemental nursing services agency, as defined by section  
33.4 144A.70.

33.5 (b) If a facility or program is licensed by the Department of Human Services and the  
33.6 Department of Health and is subject to the background study provisions of this chapter, the  
33.7 Department of Human Services is solely responsible for the background studies of individuals  
33.8 in the jointly licensed program.

33.9 Subd. 5b. Facilities serving children or youth licensed by the Department of  
33.10 Corrections. (a) The commissioner shall conduct background studies of individuals providing  
33.11 services in secure and nonsecure residential facilities and detention facilities who have direct  
33.12 contact, as defined under section 245C.02, subdivision 11, with persons served in the  
33.13 facilities.

33.14 (b) A clerk or administrator of any court, the Bureau of Criminal Apprehension, a  
33.15 prosecuting attorney, a county sheriff, or a chief of a local police department shall assist in  
33.16 conducting background studies by providing the commissioner of human services or the  
33.17 commissioner's representative with all criminal conviction data available from local, state,  
33.18 and national criminal history record repositories, related to applicants, operators, all persons  
33.19 living in a household, and all staff of any facility subject to background studies under this  
33.20 subdivision.

33.21 (c) For the purpose of this subdivision, the term "secure and nonsecure residential facility  
33.22 and detention facility" includes programs licensed or certified under section 241.021,  
33.23 subdivision 2.

33.24 (d) If an individual is disqualified, the Department of Human Services shall notify the  
33.25 disqualified individual and the facility in which the disqualified individual provides services  
33.26 and shall inform the disqualified individual of the right to request a reconsideration of the  
33.27 disqualification by submitting the request to the Department of Corrections.

33.28 (e) The commissioner of corrections shall review and make decisions regarding  
33.29 reconsideration requests, including whether to grant variances, according to the procedures  
33.30 and criteria in this chapter. The commissioner of corrections shall inform the requesting  
33.31 individual and the Department of Human Services of the commissioner's decision. The  
33.32 commissioner's decision to grant or deny a reconsideration of a disqualification is the final  
33.33 administrative agency action.

34.1 Subd. 6. **Unlicensed home and community-based waiver providers of service to**  
 34.2 **seniors and individuals with disabilities.** The commissioner shall conduct background  
 34.3 studies ~~on~~ of any individual required under section 256B.4912 to have a background study  
 34.4 ~~completed under this chapter~~ who provides direct contact, as defined in section 245C.02,  
 34.5 subdivision 11, for services specified in the federally approved home and community-based  
 34.6 waiver plans under section 256B.4712 and the individual studied must meet the requirements  
 34.7 of this chapter prior to providing waiver services and as part of ongoing enrollment. Upon  
 34.8 federal approval, this requirement applies to consumer-directed community supports.

34.9 Subd. 6a. **Legal nonlicensed and certified child care programs.** The commissioner  
 34.10 shall conduct background studies ~~on an individual~~ of the following individuals as required  
 34.11 under ~~by~~ sections 119B.125 and 245H.10 ~~to complete a background study under this chapter:~~

34.12 (1) every individual who applies for certification;

34.13 (2) every member of a provider's household who is age 13 and older; and

34.14 (3) an individual who is at least ten years of age and under 13 years of age and lives in  
 34.15 the household where the nonlicensed child care will be provided when the county has  
 34.16 reasonable cause as defined under section 245C.02, subdivision 15.

34.17 Subd. 7. **Children's therapeutic services and supports providers.** The commissioner  
 34.18 shall conduct background studies ~~according to this chapter when initiated by a children's~~  
 34.19 ~~therapeutic services and supports provider~~ of all direct service providers and volunteers for  
 34.20 children's therapeutic services and supports providers under section 256B.0943.

34.21 Subd. 8. **Self-initiated background studies.** Upon implementation of NETStudy 2.0,  
 34.22 the commissioner shall conduct background studies according to this chapter when initiated  
 34.23 by an individual who is not on the master roster. A subject under this subdivision who is  
 34.24 not disqualified must be placed on the inactive roster.

34.25 Subd. 9. **Community first services and supports organizations.** ~~The commissioner~~  
 34.26 ~~shall conduct background studies on any individual required under section 256B.85 to have~~  
 34.27 ~~a background study completed under this chapter.~~ Individuals affiliated with Community  
 34.28 First Services and Supports (CFSS) agency-providers and Financial Management Services  
 34.29 (FMS) providers enrolled to provide CFSS services under the medical assistance program  
 34.30 must meet the following requirements:

34.31 (1) owners who have a five percent interest or more and all managing employees are  
 34.32 subject to a background study under this chapter. This requirement applies to currently  
 34.33 enrolled providers and agencies seeking enrollment. "Managing employee" has the meaning

35.1 given in Code of Federal Regulations, title 42, section 455.101. An organization is barred  
 35.2 from enrollment if:

35.3 (i) the organization has not initiated background studies of owners and managing  
 35.4 employees; or

35.5 (ii) the organization has initiated background studies of owners and managing employees  
 35.6 and the commissioner has sent the organization a notice that an owner or managing employee  
 35.7 of the organization has been disqualified under section 245C.14 and the owner or managing  
 35.8 employee has not received a set aside of the disqualification under section 245C.22;

35.9 (2) a background study must be initiated and completed for all staff who will have direct  
 35.10 contact with the participant to provide worker training and development; and

35.11 (3) a background study must be initiated and completed for all support workers.

35.12 Subd. 9a. **Exception to support worker requirements for continuity of services.** The  
 35.13 support worker for a participant may enroll with a different Community First Services and  
 35.14 Supports (CFSS) agency-provider or Financial Management Services (FMS) provider upon  
 35.15 initiation, rather than completion, of a new background study according to this chapter if:

35.16 (1) the commissioner determines that the support worker's change in enrollment or  
 35.17 affiliation is necessary to ensure continuity of services and to protect the health and safety  
 35.18 of the participant;

35.19 (2) the chosen agency-provider or FMS provider has been continuously enrolled as a  
 35.20 CFSS agency-provider or FMS provider for at least two years or since the inception of the  
 35.21 CFSS program, whichever is shorter;

35.22 (3) the participant served by the support worker chooses to transfer to the CFSS  
 35.23 agency-provider or the FMS provider to which the support worker is transferring;

35.24 (4) the support worker has been continuously enrolled with the former CFSS  
 35.25 agency-provider or FMS provider since the support worker's last background study was  
 35.26 completed; and

35.27 (5) the support worker continues to meet the requirements of section 256B.85, subdivision  
 35.28 16, notwithstanding paragraph (a), clause (1).

35.29 Subd. 10. **Providers of group residential housing or supplementary services.** (a) The  
 35.30 commissioner shall conduct background studies ~~on any individual required under section~~  
 35.31 ~~256I.04 to have a background study completed under this chapter.~~ of the following individuals  
 35.32 who provide services under section 256I.04:

36.1 (1) controlling individuals as defined in section 245A.02;

36.2 (2) managerial officials as defined in section 245A.02; and

36.3 (3) all employees and volunteers of the establishment who have direct contact with  
 36.4 recipients or who have unsupervised access to recipients, recipients' personal property, or  
 36.5 recipients' private data.

36.6 (b) The provider of housing support must comply with all requirements for entities  
 36.7 initiating background studies under this chapter.

36.8 (c) A provider of housing support must demonstrate that all individuals who are required  
 36.9 to have a background study according to paragraph (a) have a notice stating that:

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

36.11 (2) the individual is disqualified and the individual has been issued a set aside of the  
 36.12 disqualification for the setting under section 245C.22.

36.13 ~~Subd. 11. **Child protection workers or social services staff having responsibility for**~~  
 36.14 ~~**child protective duties.** (a) The commissioner must complete background studies, according~~  
 36.15 ~~to paragraph (b) and section 245C.04, subdivision 10, when initiated by a county social~~  
 36.16 ~~services agency or by a local welfare agency according to section 626.559, subdivision 1b.~~

36.17 ~~(b) For background studies completed by the commissioner under this subdivision, the~~  
 36.18 ~~commissioner shall not make a disqualification decision, but shall provide the background~~  
 36.19 ~~study information received to the county that initiated the study.~~

36.20 **Subd. 12. Providers of special transportation service.** (a) The commissioner shall  
 36.21 conduct background studies on any individual required under section 174.30 to have a  
 36.22 background study completed under this chapter. of the following individuals who provide  
 36.23 special transportation services under section 174.30:

36.24 (1) each person with a direct or indirect ownership interest of five percent or higher in  
 36.25 a transportation service provider;

36.26 (2) each controlling individual as defined under section 245A.02;

36.27 (3) a managerial official as defined in section 245A.02;

36.28 (4) each driver employed by the transportation service provider;

36.29 (5) each individual employed by the transportation service provider to assist a passenger  
 36.30 during transport; and

37.1 (6) each employee of the transportation service agency who provides administrative  
 37.2 support, including an employee who:

37.3 (i) may have face-to-face contact with or access to passengers, passengers' personal  
 37.4 property, or passengers' private data;

37.5 (ii) performs any scheduling or dispatching tasks; or

37.6 (iii) performs any billing activities.

37.7 (b) When a local or contracted agency is authorizing a ride under section 256B.0625,  
 37.8 subdivision 17, by a volunteer driver, and the agency authorizing the ride has a reason to  
 37.9 believe that the volunteer driver has a history that would disqualify the volunteer driver or  
 37.10 that may pose a risk to the health or safety of passengers, the agency may initiate a  
 37.11 background study that shall be completed according to this chapter using the commissioner  
 37.12 of human services' online NETStudy system, or by contacting the Department of Human  
 37.13 Services background study division for assistance. The agency that initiates the background  
 37.14 study under this paragraph shall be responsible for providing the volunteer driver with the  
 37.15 privacy notice required by section 245C.05, subdivision 2c, and with the payment for the  
 37.16 background study required by section 245C.10 before the background study is completed.

37.17 **Subd. 13. Providers of housing support services.** The commissioner shall conduct  
 37.18 background studies ~~on~~ of any individual provider of housing support services required ~~under~~  
 37.19 by section 256B.051 to have a background study completed under this chapter.

37.20 **Subd. 14. Tribal nursing facilities.** For completed background studies to comply with  
 37.21 a tribal organization's licensing requirements for individuals affiliated with a tribally licensed  
 37.22 nursing facility, the commissioner shall obtain state and national criminal history data  
 37.23 according to section 245C.32.

37.24 Sec. 8. Minnesota Statutes 2020, section 245C.03, is amended by adding a subdivision to  
 37.25 read:

37.26 **Subd. 15. Early intensive developmental and behavioral intervention providers.** The  
 37.27 commissioner shall conduct background studies according to this chapter when initiated by  
 37.28 an early intensive developmental and behavioral intervention provider under section  
 37.29 256B.0949.

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

38.1 **Sec. 9. [245C.031] BACKGROUND STUDY; ALTERNATIVE BACKGROUND**  
38.2 **STUDIES.**

38.3 Subdivision 1. **Alternative background studies.** (a) The commissioner shall conduct  
38.4 an alternative background study of individuals listed in this section.

38.5 (b) Notwithstanding other sections of this chapter, all alternative background studies  
38.6 except subdivision 9 shall be conducted according to this section and with section 299C.60  
38.7 to 299C.64.

38.8 (c) All terms in this section shall have the definitions provided in section 245C.02.

38.9 (d) The entity that submits an alternative background study request under this section  
38.10 shall submit the request to the commissioner according to section 245C.05.

38.11 (e) The commissioner shall comply with the destruction requirements in section 245C.051.

38.12 (f) Background studies conducted under this section are subject to the provisions of  
38.13 section 245C.32.

38.14 (g) The commissioner shall forward all information that the commissioner receives under  
38.15 section 245C.08 to the entity that submitted the alternative background study request under  
38.16 subdivision 2. The commissioner shall not make any eligibility determinations regarding  
38.17 background studies conducted under this section.

38.18 Subd. 2. **Access to information.** Each entity that submits an alternative background  
38.19 study request shall enter into an agreement with the commissioner before submitting requests  
38.20 for alternative background studies under this section. As a part of the agreement, the entity  
38.21 must agree to comply with state and federal law.

38.22 Subd. 3. **Child protection workers or social services staff having responsibility for**  
38.23 **child protective duties.** The commissioner shall conduct an alternative background study  
38.24 of any person who has responsibility for child protection duties when the background study  
38.25 is initiated by a county social services agency or by a local welfare agency according to  
38.26 section 260E.36, subdivision 3.

38.27 Subd. 4. **Applicants, licensees, and other occupations regulated by the commissioner**  
38.28 **of health.** The commissioner shall conduct an alternative background study, including a  
38.29 check of state data, and a national criminal history records check of the following individuals.  
38.30 The check must be structured so that any new crimes that an applicant or licensee or  
38.31 certificate holder commits after the initial background check are flagged in the Bureau of  
38.32 Criminal Apprehension's or Federal Bureau of Investigation's database and reported to the

39.1 commissioner of human services. For studies under this section, the following persons shall  
39.2 complete a consent form:

39.3 (1) an applicant for initial licensure, temporary licensure, or relicensure after a lapse in  
39.4 licensure as an audiologist or speech-language pathologist or an applicant for initial  
39.5 certification as a hearing instrument dispenser who must submit to a background study  
39.6 under section 144.0572.

39.7 (2) an applicant for a renewal license or certificate as an audiologist, speech-language  
39.8 pathologist, or hearing instrument dispenser who was licensed or obtained a certificate  
39.9 before January 1, 2018.

39.10 Subd. 5. **Guardians and conservators.** (a) The commissioner shall conduct an alternative  
39.11 background study of:

39.12 (1) every court-appointed guardian and conservator, unless a background study has been  
39.13 completed of the person under this section within the previous five years. The alternative  
39.14 background study shall be completed prior to the appointment of the guardian or conservator,  
39.15 unless a court determines that it would be in the best interests of the ward or protected person  
39.16 to appoint a guardian or conservator before the alternative background study can be  
39.17 completed. If the court appoints the guardian or conservator while the alternative background  
39.18 study is pending, the alternative background study must be completed as soon as reasonably  
39.19 possible after the guardian or conservator's appointment and no later than 30 days after the  
39.20 guardian or conservator's appointment; and

39.21 (2) a guardian and a conservator once every five years after the guardian or conservator's  
39.22 appointment if the person continues to serve as a guardian or conservator.

39.23 (b) An alternative background study is not required if the guardian or conservator is:

39.24 (1) a state agency or county;

39.25 (2) a parent or guardian of a proposed ward or protected person who has a developmental  
39.26 disability if the parent or guardian has raised the proposed ward or protected person in the  
39.27 family home until the time that the petition is filed, unless counsel appointed for the proposed  
39.28 ward or protected person under section 524.5-205, paragraph (d); 524.5-304, paragraph (b);  
39.29 524.5-405, paragraph (a); or 524.5-406, paragraph (b), recommends a background study;  
39.30 or

39.31 (3) a bank with trust powers, a bank and trust company, or a trust company, organized  
39.32 under the laws of any state or of the United States and regulated by the commissioner of  
39.33 commerce or a federal regulator.

40.1 Subd. 6. Required checks. (a) An alternative background study pursuant to subdivision  
40.2 5 shall include:

40.3 (1) criminal history data from the Bureau of Criminal Apprehension and other criminal  
40.4 history data held by the commissioner of human services;

40.5 (2) data regarding whether the person has been a perpetrator of substantiated maltreatment  
40.6 of a vulnerable adult under section 626.557 or a minor under chapter 260E. If the subject  
40.7 of the study has been the perpetrator of substantiated maltreatment of a vulnerable adult or  
40.8 a minor, the commissioner must include a copy of the public portion of the investigation  
40.9 memorandum under section 626.557, subdivision 12b, or the public portion of the  
40.10 investigation memorandum under section 260E.30. The commissioner shall provide the  
40.11 court with information from a review of information according to subdivision 7 if the study  
40.12 subject provided information that the study subject has a current or prior affiliation with a  
40.13 state licensing agency;

40.14 (3) criminal history data from a national criminal history record check as defined in  
40.15 section 245C.02, subdivision 13c; and

40.16 (4) state licensing agency data if a search of the database or databases of the agencies  
40.17 listed in subdivision 7 shows that the proposed guardian or conservator has held a  
40.18 professional license directly related to the responsibilities of a professional fiduciary from  
40.19 an agency listed in subdivision 7 that was conditioned, suspended, revoked, or canceled.

40.20 (b) If the guardian or conservator is not an individual, the background study must be  
40.21 completed of all individuals who are currently employed by the proposed guardian or  
40.22 conservator who are responsible for exercising powers and duties under the guardianship  
40.23 or conservatorship.

40.24 Subd. 7. State licensing data. (a) Within 25 working days of receiving the request, the  
40.25 commissioner shall provide the court with licensing agency data for licenses directly related  
40.26 to the responsibilities of a professional fiduciary if the study subject has a current or prior  
40.27 affiliation with the:

40.28 (1) Lawyers Responsibility Board;

40.29 (2) State Board of Accountancy;

40.30 (3) Board of Social Work;

40.31 (4) Board of Psychology;

40.32 (5) Board or Nursing;



41.1 (6) Board of Medical Practice;

41.2 (7) Department of Education;

41.3 (8) Department of Commerce;

41.4 (9) Board of Chiropractic Examiners;

41.5 (10) Board of Dentistry;

41.6 (11) Board of Marriage and Family Therapy;

41.7 (12) Department of Human Services;

41.8 (13) Peace Officer Standards and Training (POST) Board; and

41.9 (14) Professional Educator Licensing and Standards Board.

41.10 (b) The commissioner and each of the agencies listed above, except for the Department  
41.11 of Human Services, shall enter into a written agreement to provide the commissioner with  
41.12 electronic access to the relevant licensing data and to provide the commissioner with a  
41.13 quarterly list of new sanctions issued by the agency.

41.14 (c) The commissioner shall provide to the court the electronically available data  
41.15 maintained in the agency's database, including whether the proposed guardian or conservator  
41.16 is or has been licensed by the agency, and whether a disciplinary action or a sanction against  
41.17 the individual's license, including a condition, suspension, revocation, or cancellation is in  
41.18 the licensing agency's database.

41.19 (d) If the proposed guardian or conservator has resided in a state other than Minnesota  
41.20 during the previous ten years, licensing agency data under this section shall also include  
41.21 licensing agency data from any other state where the proposed guardian or conservator  
41.22 reported to have resided during the previous ten years if the study subject has a current or  
41.23 prior affiliation to the licensing agency. If the proposed guardian or conservator has or has  
41.24 had a professional license in another state that is directly related to the responsibilities of a  
41.25 professional fiduciary from one of the agencies listed under paragraph (a), state licensing  
41.26 agency data shall also include data from the relevant licensing agency of the other state.

41.27 (e) The commissioner is not required to repeat a search for Minnesota or out-of-state  
41.28 licensing data on an individual if the commissioner has provided this information to the  
41.29 court within the prior five years.

41.30 (f) The commissioner shall review the information in paragraph (c) at least once every  
41.31 four months to determine whether an individual who has been studied within the previous  
41.32 five years:

42.1 (1) has any new disciplinary action or sanction against the individual's license; or

42.2 (2) did not disclose a prior or current affiliation with a Minnesota licensing agency.

42.3 (g) If the commissioner's review in paragraph (f) identifies new information, the  
42.4 commissioner shall provide any new information to the court.

42.5 Subd. 8. **Guardians ad litem.** The commissioner shall conduct an alternative background  
42.6 study of:

42.7 (1) a guardian ad litem appointed under section 518.165 if a background study of the  
42.8 guardian ad litem has not been completed within the past three years. The background study  
42.9 of the guardian ad litem must be completed before the court appoints the guardian ad litem,  
42.10 unless the court determines that it is in the best interests of the child to appoint the guardian  
42.11 ad litem before a background study is completed by the commissioner.

42.12 (2) a guardian ad litem once every three years after the guardian has been appointed, as  
42.13 long as the individual continues to serve as a guardian ad litem.

42.14 Subd. 9. **Required checks.** (a) An alternative background study under subdivision 5  
42.15 must include:

42.16 (1) criminal history data from the Bureau of Criminal Apprehension and other criminal  
42.17 history data held by the commissioner of human services;

42.18 (2) data regarding whether the person has been a perpetrator of substantiated maltreatment  
42.19 of a minor or a vulnerable adult. If the study subject has been determined by the Department  
42.20 of Human Services or the Department of Health to be the perpetrator of substantiated  
42.21 maltreatment of a minor or a vulnerable adult in a licensed facility, the response must include  
42.22 a copy of the public portion of the investigation memorandum under section 260E.30 or the  
42.23 public portion of the investigation memorandum under section 626.557, subdivision 12b.  
42.24 When the background study shows that the subject has been determined by a county adult  
42.25 protection or child protection agency to have been responsible for maltreatment, the court  
42.26 shall be informed of the county, the date of the finding, and the nature of the maltreatment  
42.27 that was substantiated;

42.28 (3) when the information from the Bureau of Criminal Apprehension indicates that the  
42.29 study subject is a multistate offender or that the subject's multistate offender status is  
42.30 undetermined, the court shall require a national criminal history records check, and shall  
42.31 provide the commissioner with a set of classifiable fingerprints of the study subject.

42.32 (b) For checks of records under paragraph (a), clauses (1) and (2), the commissioner  
42.33 shall provide the investigating information within 15 working days of receiving the request.

43.1 The information obtained under sections 245C.05 and 245C.08 from a national criminal  
 43.2 history records check shall be provided within three working days of the commissioner's  
 43.3 receipt of the data.

43.4 (c) Notwithstanding section 260E.30 or 626.557, subdivision 12b, if the commissioner  
 43.5 or county lead agency or lead investigative agency has information that a person of whom  
 43.6 a background study was previously completed under this section has been determined to  
 43.7 be a perpetrator of maltreatment of a minor or vulnerable adult, the commissioner or the  
 43.8 county may provide this information to the court that requested the background study.

43.9 **Subd. 10. First-time applicants for educator licenses with the Professional Educator**  
 43.10 **Licensing and Standards Board.** The Professional Educator Licensing and Standards  
 43.11 Board shall make all eligibility determinations for alternative background studies conducted  
 43.12 under this section for the Professional Educator Licensing and Standards Board. The  
 43.13 commissioner may conduct an alternative background study of all first-time applicants for  
 43.14 educator licenses pursuant to section 122A.18, subdivision 8. The alternative background  
 43.15 study for all first-time applicants for educator licenses must include a review of information  
 43.16 from the Bureau of Criminal Apprehension, including criminal history data as defined in  
 43.17 section 13.87, and must also include a review of the national criminal records repository.

43.18 **Subd. 11. First-time applicants for administrator licenses with the Board of School**  
 43.19 **Administrators.** The Board of School Administrators shall make all eligibility determinations  
 43.20 for alternative background studies conducted under this section for the Board of School  
 43.21 Administrators. The commissioner may conduct an alternative background study of all  
 43.22 first-time applicants for administrator licenses pursuant to section 122A.18, subdivision 8.  
 43.23 The alternative background study for all first-time applicants for administrator licenses must  
 43.24 include a review of information from the Bureau of Criminal Apprehension, including  
 43.25 criminal history data as defined in section 13.87, and must also include a review of the  
 43.26 national criminal records repository.

43.27 **Subd. 12. MNsure.** The commissioner shall conduct a background study of any individual  
 43.28 required under section 62V.05 to have a background study completed under this chapter.

43.29 Sec. 10. Minnesota Statutes 2020, section 245C.05, subdivision 1, is amended to read:

43.30 Subdivision 1. **Individual studied.** (a) The individual who is the subject of the  
 43.31 background study must provide the applicant, license holder, or other entity under section  
 43.32 245C.04 with sufficient information to ensure an accurate study, including:

44.1 (1) the individual's first, middle, and last name and all other names by which the  
44.2 individual has been known;

44.3 (2) current home address, city, and state of residence;

44.4 (3) current zip code;

44.5 (4) sex;

44.6 (5) date of birth;

44.7 (6) driver's license number or state identification number; and

44.8 (7) upon implementation of NETStudy 2.0, the home address, city, county, and state of  
44.9 residence for the past five years.

44.10 (b) Every subject of a background study conducted or initiated by counties or ~~private~~  
44.11 ~~agencies~~ commissioner's delegates under this chapter must also provide the home address,  
44.12 city, county, and state of residence for the past five years.

44.13 (c) Every subject of a background study related to private agency adoptions or related  
44.14 to child foster care licensed through a private agency, who is 18 years of age or older, shall  
44.15 also provide the commissioner a signed consent for the release of any information received  
44.16 from national crime information databases to the private agency that initiated the background  
44.17 study.

44.18 (d) The subject of a background study shall provide fingerprints and a photograph as  
44.19 required in subdivision 5.

44.20 (e) The subject of a background study shall submit a completed criminal and maltreatment  
44.21 history records check consent form for applicable national and state level record checks.

44.22 Sec. 11. Minnesota Statutes 2020, section 245C.05, subdivision 2, is amended to read:

44.23 Subd. 2. **Applicant, license holder, or other entity.** (a) The applicant, license holder,  
44.24 or other ~~entities~~ entity initiating the background study as provided in this chapter shall verify  
44.25 that the information collected under subdivision 1 about an individual who is the subject of  
44.26 the background study is correct and must provide the information on forms or in a format  
44.27 prescribed by the commissioner.

44.28 (b) The information collected under subdivision 1 about an individual who is the subject  
44.29 of a completed background study may only be viewable by an entity that initiates a  
44.30 subsequent background study on that individual under NETStudy 2.0 after the entity has

45.1 paid the applicable fee for the study and has provided the individual with the privacy notice  
45.2 in subdivision 2c.

45.3 Sec. 12. Minnesota Statutes 2020, section 245C.05, subdivision 2a, is amended to read:

45.4 Subd. 2a. **County or private agency.** For background studies related to child foster care  
45.5 when the applicant or license holder resides in the home where child foster care services  
45.6 are provided, county and private agencies initiating the background study must collect the  
45.7 information under subdivision 1 and forward it to the commissioner.

45.8 Sec. 13. Minnesota Statutes 2020, section 245C.05, subdivision 2b, is amended to read:

45.9 Subd. 2b. **County agency to collect and forward information to commissioner.** (a)  
45.10 For background studies related to all family adult day services and to adult foster care when  
45.11 the adult foster care license holder resides in the adult foster care residence, the county  
45.12 agency or private agency initiating the background study must collect the information  
45.13 required under subdivision 1 and forward it to the commissioner.

45.14 (b) Upon implementation of NETStudy 2.0, for background studies related to family  
45.15 child care and legal nonlicensed child care authorized under chapter 119B, the county agency  
45.16 initiating the background study must collect the information required under subdivision 1  
45.17 and provide the information to the commissioner.

45.18 Sec. 14. Minnesota Statutes 2020, section 245C.05, subdivision 4, is amended to read:

45.19 Subd. 4. **Electronic transmission.** (a) For background studies conducted by the  
45.20 Department of Human Services, the commissioner shall implement a secure system for the  
45.21 electronic transmission of:

45.22 (1) background study information to the commissioner;

45.23 (2) background study results to the license holder;

45.24 (3) background study ~~results~~ information obtained under this section and section 245C.08  
45.25 to counties and private agencies for background studies conducted by the commissioner for  
45.26 child foster care; and

45.27 (4) background study results to county agencies for background studies conducted by  
45.28 the commissioner for adult foster care and family adult day services and, upon  
45.29 implementation of NETStudy 2.0, family child care and legal nonlicensed child care  
45.30 authorized under chapter 119B.

46.1 (b) Unless the commissioner has granted a hardship variance under paragraph (c), a  
46.2 license holder or an applicant must use the electronic transmission system known as  
46.3 NETStudy or NETStudy 2.0 to submit all requests for background studies to the  
46.4 commissioner as required by this chapter.

46.5 (c) A license holder or applicant whose program is located in an area in which high-speed  
46.6 Internet is inaccessible may request the commissioner to grant a variance to the electronic  
46.7 transmission requirement.

46.8 (d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under  
46.9 this subdivision.

46.10 (e) Information obtained under this section and section 245C.08 applies to state and  
46.11 tribal agencies for alternative studies under section 245C.031.

46.12 Sec. 15. Minnesota Statutes 2020, section 245C.08, is amended by adding a subdivision  
46.13 to read:

46.14 Subd. 5. **Authorized recipient.** The commissioner of human services shall be the  
46.15 authorized recipient of information and records received under this chapter.

46.16 Sec. 16. Minnesota Statutes 2020, section 245C.08, is amended by adding a subdivision  
46.17 to read:

46.18 Subd. 6. **Bureau of Criminal Apprehension background check crimes.** When  
46.19 applicable, all background studies conducted under this chapter shall comply with the  
46.20 requirements of sections 299C.60 to 299C.64.

46.21 Sec. 17. Minnesota Statutes 2020, section 245C.10, subdivision 15, is amended to read:

46.22 ~~Subd. 15. **Guardians and conservators.** The commissioner shall recover the cost of~~  
46.23 ~~conducting background studies for guardians and conservators under section 524.5-118~~  
46.24 ~~through a fee of no more than \$110 per study. The fees collected under this subdivision are~~  
46.25 ~~appropriated to the commissioner for the purpose of conducting background studies. fee~~  
46.26 for conducting an alternative background study for appointment of a professional guardian  
46.27 or conservator must be paid by the guardian or conservator. In other cases, the fee must be  
46.28 paid as follows:

46.29 (1) if the matter is proceeding in forma pauperis, the fee must be paid as an expense for  
46.30 purposes of section 524.5-502, paragraph (a);

47.1 (2) if there is an estate of the ward or protected person, the fee must be paid from the  
47.2 estate; or

47.3 (3) in the case of a guardianship or conservatorship of a person that is not proceeding  
47.4 in forma pauperis, the fee must be paid by the guardian, conservator, or the court.

47.5 Sec. 18. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision  
47.6 to read:

47.7 Subd. 17. **Early intensive developmental and behavioral intervention providers.** The  
47.8 commissioner shall recover the cost of background studies required under section 245C.03,  
47.9 subdivision 15, for the purposes of early intensive developmental and behavioral intervention  
47.10 under section 256B.0949, through a fee of no more than \$20 per study charged to the enrolled  
47.11 agency. The fees collected under this subdivision are appropriated to the commissioner for  
47.12 the purpose of conducting background studies.

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

47.14 Sec. 19. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision  
47.15 to read:

47.16 Subd. 18. **Applicants, licensees, and other occupations regulated by commissioner**  
47.17 **of health.** The applicant or license holder is responsible for paying to the Department of  
47.18 Human Services all fees associated with the preparation of the fingerprints, the criminal  
47.19 records check consent form, and the criminal background check.

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

47.22 Subd. 19. **Guardians ad litem.** The Minnesota Supreme Court shall pay the commissioner  
47.23 a fee for conducting an alternative background study.

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

47.26 Subd. 20. **Occupations regulated by MNsure.** The commissioner shall set fees to  
47.27 recover the cost of background studies and criminal background checks initiated by MNsure  
47.28 under sections 62V.05 and 245C.03. The fee amount shall be established through interagency  
47.29 agreement between the commissioner and the board of MNsure or its designee. The fees  
47.30 collected under this subdivision shall be deposited in the special revenue fund and are

48.1 appropriated to the commissioner for the purpose of conducting background studies and  
48.2 criminal background checks.

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

48.5 Subd. 21. **Professional Educators Licensing Standards Board.** The commissioner  
48.6 shall recover the cost of background studies initiated by the Professional Educators Licensing  
48.7 Standards Board through a fee of no more than \$51 per study. Fees collected under this  
48.8 subdivision are appropriated to the commissioner for purposes of conducting background  
48.9 studies.

48.10 Sec. 23. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision  
48.11 to read:

48.12 Subd. 22. **Board of School Administrators.** The commissioner shall recover the cost  
48.13 of background studies initiated by the Board of School Administrators through a fee of no  
48.14 more than \$51 per study. Fees collected under this subdivision are appropriated to the  
48.15 commissioner for purposes of conducting background studies.

48.16 Sec. 24. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision  
48.17 to read:

48.18 Subd. 23. **Background studies fee schedule.** (a) By March 1 each year, the commissioner  
48.19 shall publish a schedule of fees sufficient to administer and conduct background studies  
48.20 under this chapter. The published schedule of fees shall be effective on July 1 each year.

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

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

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

48.29 (e) The fees collected under this subdivision are appropriated to the commissioner for  
48.30 the purpose of conducting background studies.



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

49.4 Sec. 25. Minnesota Statutes 2020, section 245C.13, subdivision 2, is amended to read:

49.5 Subd. 2. **Activities pending completion of background study.** The subject of a  
49.6 background study may not perform any activity requiring a background study under  
49.7 paragraph (c) until the commissioner has issued one of the notices under paragraph (a).

49.8 (a) Notices from the commissioner required prior to activity under paragraph (c) include:

49.9 (1) a notice of the study results under section 245C.17 stating that:

49.10 (i) the individual is not disqualified; or

49.11 (ii) more time is needed to complete the study but the individual is not required to be  
49.12 removed from direct contact or access to people receiving services prior to completion of  
49.13 the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice  
49.14 that more time is needed to complete the study must also indicate whether the individual is  
49.15 required to be under continuous direct supervision prior to completion of the background  
49.16 study. When more time is necessary to complete a background study of an individual  
49.17 affiliated with a Title IV-E eligible children's residential facility or foster residence setting,  
49.18 the individual may not work in the facility or setting regardless of whether or not the  
49.19 individual is supervised;

49.20 (2) a notice that a disqualification has been set aside under section 245C.23; or

49.21 (3) a notice that a variance has been granted related to the individual under section  
49.22 245C.30.

49.23 (b) For a background study affiliated with a licensed child care center or certified  
49.24 license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii),  
49.25 must require the individual to be under continuous direct supervision prior to completion  
49.26 of the background study except as permitted in subdivision 3.

49.27 (c) Activities prohibited prior to receipt of notice under paragraph (a) include:

49.28 (1) being issued a license;

49.29 (2) living in the household where the licensed program will be provided;

49.30 (3) providing direct contact services to persons served by a program unless the subject  
49.31 is under continuous direct supervision;

50.1 (4) having access to persons receiving services if the background study was completed  
 50.2 under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2),  
 50.3 (5), or (6), unless the subject is under continuous direct supervision;

50.4 (i) not disqualified under section 245C.14; or

50.5 (ii) disqualified, but the personal care assistant has received a set aside of the  
 50.6 disqualification under section 245C.22;

50.7 (5) for licensed child care centers and certified license-exempt child care centers,  
 50.8 providing direct contact services to persons served by the program; ~~or~~

50.9 (6) for children's residential facilities or foster residence settings, working in the facility  
 50.10 or setting; or

50.11 (7) for background studies affiliated with a personal care provider organization, except  
 50.12 as provided in section 245C.03, subdivision 3a, before a personal care assistant provides  
 50.13 services, the personal care assistance provider agency must initiate a background study of  
 50.14 the personal care assistant under this chapter and the personal care assistance provider  
 50.15 agency must have received a notice from the commissioner that the personal care assistant  
 50.16 is:

50.17 (i) not disqualified under section 245C.14; or

50.18 (ii) disqualified, but the personal care assistant has received a set aside of the  
 50.19 disqualification under section 245C.22.

50.20 Sec. 26. Minnesota Statutes 2020, section 245C.14, is amended by adding a subdivision  
 50.21 to read:

50.22 **Subd. 4. Disqualification from working in licensed child care centers or certified**  
 50.23 **license-exempt child care centers.** (a) For a background study affiliated with a licensed  
 50.24 child care center or certified license-exempt child care center, if an individual is disqualified  
 50.25 from direct contact under subdivision 1, the commissioner must also disqualify the individual  
 50.26 from working in any position regardless of whether the individual would have direct contact  
 50.27 with or access to children served in the licensed child care center or certified license-exempt  
 50.28 child care center and from having access to a person receiving services from the center.

50.29 (b) Notwithstanding any other requirement of this chapter, for a background study  
 50.30 affiliated with a licensed child care center or a certified license-exempt child care center, if  
 50.31 an individual is disqualified, the individual may not work in the child care center until the  
 50.32 commissioner has issued a notice stating that:

- 51.1 (1) the individual is not disqualified;  
 51.2 (2) a disqualification has been set aside under section 245C.23; or  
 51.3 (3) a variance has been granted related to the individual under section 245C.30.

51.4 Sec. 27. Minnesota Statutes 2020, section 245C.16, subdivision 1, is amended to read:

51.5 Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines  
 51.6 that the individual studied has a disqualifying characteristic, the commissioner shall review  
 51.7 the information immediately available and make a determination as to the subject's immediate  
 51.8 risk of harm to persons served by the program where the individual studied will have direct  
 51.9 contact with, or access to, people receiving services.

51.10 (b) The commissioner shall consider all relevant information available, including the  
 51.11 following factors in determining the immediate risk of harm:

- 51.12 (1) the recency of the disqualifying characteristic;  
 51.13 (2) the recency of discharge from probation for the crimes;  
 51.14 (3) the number of disqualifying characteristics;  
 51.15 (4) the intrusiveness or violence of the disqualifying characteristic;  
 51.16 (5) the vulnerability of the victim involved in the disqualifying characteristic;  
 51.17 (6) the similarity of the victim to the persons served by the program where the individual  
 51.18 studied will have direct contact;  
 51.19 (7) whether the individual has a disqualification from a previous background study that  
 51.20 has not been set aside; ~~and~~  
 51.21 (8) if the individual has a disqualification which may not be set aside because it is a  
 51.22 permanent bar under section 245C.24, subdivision 1, or the individual is a child care  
 51.23 background study subject who has a felony-level conviction for a drug-related offense in  
 51.24 the last five years, the commissioner may order the immediate removal of the individual  
 51.25 from any position allowing direct contact with, or access to, persons receiving services from  
 51.26 the program and from working in a children's residential facility or foster residence setting;  
 51.27 and

- 51.28 (9) if the individual has a disqualification which may not be set aside because it is a  
 51.29 permanent bar under section 245C.24, subdivision 2, or the individual is a child care  
 51.30 background study subject who has a felony-level conviction for a drug-related offense during  
 51.31 the last five years, the commissioner may order the immediate removal of the individual

52.1 from any position allowing direct contact with or access to persons receiving services from  
 52.2 the center and from working in a licensed child care center or certified license-exempt child  
 52.3 care center.

52.4 (c) This section does not apply when the subject of a background study is regulated by  
 52.5 a health-related licensing board as defined in chapter 214, and the subject is determined to  
 52.6 be responsible for substantiated maltreatment under section 626.557 or chapter 260E.

52.7 (d) This section does not apply to a background study related to an initial application  
 52.8 for a child foster family setting license.

52.9 (e) Except for paragraph (f), this section does not apply to a background study that is  
 52.10 also subject to the requirements under section 256B.0659, subdivisions 11 and 13, for a  
 52.11 personal care assistant or a qualified professional as defined in section 256B.0659,  
 52.12 subdivision 1.

52.13 (f) If the commissioner has reason to believe, based on arrest information or an active  
 52.14 maltreatment investigation, that an individual poses an imminent risk of harm to persons  
 52.15 receiving services, the commissioner may order that the person be continuously supervised  
 52.16 or immediately removed pending the conclusion of the maltreatment investigation or criminal  
 52.17 proceedings.

52.18 Sec. 28. Minnesota Statutes 2020, section 245C.16, subdivision 2, is amended to read:

52.19 Subd. 2. **Findings.** (a) After evaluating the information immediately available under  
 52.20 subdivision 1, the commissioner may have reason to believe one of the following:

52.21 (1) the individual poses an imminent risk of harm to persons served by the program  
 52.22 where the individual studied will have direct contact or access to persons served by the  
 52.23 program or where the individual studied will work;

52.24 (2) the individual poses a risk of harm requiring continuous, direct supervision while  
 52.25 providing direct contact services during the period in which the subject may request a  
 52.26 reconsideration; or

52.27 (3) the individual does not pose an imminent risk of harm or a risk of harm requiring  
 52.28 continuous, direct supervision while providing direct contact services during the period in  
 52.29 which the subject may request a reconsideration.

52.30 (b) After determining an individual's risk of harm under this section, the commissioner  
 52.31 must notify the subject of the background study and the applicant or license holder as  
 52.32 required under section 245C.17.

53.1 (c) For Title IV-E eligible children's residential facilities and foster residence settings,  
53.2 the commissioner is prohibited from making the findings in paragraph (a), clause (2) or (3).

53.3 (d) For licensed child care centers or certified license-exempt child care centers, the  
53.4 commissioner is prohibited from making the findings in paragraph (a), clause (2) or (3).

53.5 Sec. 29. Minnesota Statutes 2020, section 245C.17, subdivision 1, is amended to read:

53.6 Subdivision 1. **Time frame for notice of study results and auditing system access.** (a)  
53.7 Within three working days after the commissioner's receipt of a request for a background  
53.8 study submitted through the commissioner's NETStudy or NETStudy 2.0 system, the  
53.9 commissioner shall notify the background study subject and the license holder or other  
53.10 entity as provided in this chapter in writing or by electronic transmission of the results of  
53.11 the study or that more time is needed to complete the study. The notice to the individual  
53.12 shall include the identity of the entity that initiated the background study.

53.13 (b) Before being provided access to NETStudy 2.0, the license holder or other entity  
53.14 under section 245C.04 shall sign an acknowledgment of responsibilities form developed  
53.15 by the commissioner that includes identifying the sensitive background study information  
53.16 person, who must be an employee of the license holder or entity. All queries to NETStudy  
53.17 2.0 are electronically recorded and subject to audit by the commissioner. The electronic  
53.18 record shall identify the specific user. A background study subject may request in writing  
53.19 to the commissioner a report listing the entities that initiated a background study on the  
53.20 individual.

53.21 (c) When the commissioner has completed a prior background study on an individual  
53.22 that resulted in an order for immediate removal and more time is necessary to complete a  
53.23 subsequent study, the notice that more time is needed that is issued under paragraph (a)  
53.24 shall include an order for immediate removal of the individual from any position allowing  
53.25 direct contact with or access to people receiving services and from working in a children's  
53.26 residential facility ~~or~~, foster residence setting, child care center, or certified license-exempt  
53.27 child care center pending completion of the background study.

53.28 Sec. 30. Minnesota Statutes 2020, section 245C.17, is amended by adding a subdivision  
53.29 to read:

53.30 Subd. 8. Disqualification notice to child care centers and certified license-exempt  
53.31 child care centers. (a) For child care centers and certified license-exempt child care centers,  
53.32 all notices under this section that order the license holder to immediately remove the  
53.33 individual studied from any position allowing direct contact with, or access to a person

54.1 served by the center, must also order the license holder to immediately remove the individual  
 54.2 studied from working in any position regardless of whether the individual would have direct  
 54.3 contact with or access to children served in the center.

54.4 (b) For child care centers and certified license-exempt child care centers, notices under  
 54.5 this section must not allow an individual to work in the center.

54.6 Sec. 31. Minnesota Statutes 2020, section 245C.18, is amended to read:

54.7 **245C.18 OBLIGATION TO REMOVE DISQUALIFIED INDIVIDUAL FROM**  
 54.8 **DIRECT CONTACT AND FROM WORKING IN A PROGRAM, FACILITY, ~~OR~~**  
 54.9 **SETTING, OR CENTER.**

54.10 (a) Upon receipt of notice from the commissioner, the license holder must remove a  
 54.11 disqualified individual from direct contact with persons served by the licensed program if:

54.12 (1) the individual does not request reconsideration under section 245C.21 within the  
 54.13 prescribed time;

54.14 (2) the individual submits a timely request for reconsideration, the commissioner does  
 54.15 not set aside the disqualification under section 245C.22, subdivision 4, and the individual  
 54.16 does not submit a timely request for a hearing under sections 245C.27 and 256.045, or  
 54.17 245C.28 and chapter 14; or

54.18 (3) the individual submits a timely request for a hearing under sections 245C.27 and  
 54.19 256.045, or 245C.28 and chapter 14, and the commissioner does not set aside or rescind the  
 54.20 disqualification under section 245A.08, subdivision 5, or 256.045.

54.21 (b) For children's residential facility and foster residence setting license holders, upon  
 54.22 receipt of notice from the commissioner under paragraph (a), the license holder must also  
 54.23 remove the disqualified individual from working in the program, facility, or setting and  
 54.24 from access to persons served by the licensed program.

54.25 (c) For Title IV-E eligible children's residential facility and foster residence setting  
 54.26 license holders, upon receipt of notice from the commissioner under paragraph (a), the  
 54.27 license holder must also remove the disqualified individual from working in the program  
 54.28 and from access to persons served by the program and must not allow the individual to work  
 54.29 in the facility or setting until the commissioner has issued a notice stating that:

54.30 (1) the individual is not disqualified;

54.31 (2) a disqualification has been set aside under section 245C.23; or

54.32 (3) a variance has been granted related to the individual under section 245C.30.

55.1 (d) For licensed child care center and certified license-exempt child care center license  
 55.2 holders, upon receipt of notice from the commissioner under paragraph (a), the license  
 55.3 holder must remove the disqualified individual from working in any position regardless of  
 55.4 whether the individual would have direct contact with or access to children served in the  
 55.5 center and from having access to persons served by the center and must not allow the  
 55.6 individual to work in the center until the commissioner has issued a notice stating that:

55.7 (1) the individual is not disqualified;

55.8 (2) a disqualification has been set aside under section 245C.23; or

55.9 (3) a variance has been granted related to the individual under section 245C.30.

55.10 Sec. 32. Minnesota Statutes 2020, section 256B.0949, is amended by adding a subdivision  
 55.11 to read:

55.12 Subd. 16a. **Background studies.** The requirements for background studies under this  
 55.13 section shall be met by an early intensive developmental and behavioral intervention services  
 55.14 agency through the commissioner's NETStudy system as provided under sections 245C.03,  
 55.15 subdivision 15, and 245C.10, subdivision 17.

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

55.17 Sec. 33. **REVISOR INSTRUCTION.**

55.18 The revisor of statutes shall renumber Minnesota Statutes, section 245C.02, so that the  
 55.19 subdivisions are alphabetical. The revisor shall correct any cross-references that arise as a  
 55.20 result of the renumbering.

55.21 Sec. 34. **REPEALER.**

55.22 Minnesota Statutes 2020, section 245C.10, subdivisions 2, 2a, 3, 4, 5, 6, 7, 8, 9, 9a, 10,  
 55.23 11, 12, 13, 14, and 16, are repealed.

### 55.24 **ARTICLE 3**

#### 55.25 **BLUE RIBBON COMMISSION**

55.26 Section 1. Minnesota Statutes 2020, section 174.30, subdivision 3, is amended to read:

55.27 **Subd. 3. Other standards; wheelchair securement; protected transport.** (a) A special  
 55.28 transportation service that transports individuals occupying wheelchairs is subject to the  
 55.29 provisions of sections 299A.11 to 299A.17 concerning wheelchair securement devices. The  
 55.30 commissioners of transportation and public safety shall cooperate in the enforcement of

56.1 this section and sections 299A.11 to 299A.17 so that a single inspection is sufficient to  
 56.2 ascertain compliance with sections 299A.11 to 299A.17 and with the standards adopted  
 56.3 under this section. Representatives of the Department of Transportation may inspect  
 56.4 wheelchair securement devices in vehicles operated by special transportation service  
 56.5 providers to determine compliance with sections 299A.11 to 299A.17 and to issue certificates  
 56.6 under section 299A.14, subdivision 4.

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

56.11 (c) For vehicles designated as protected transport under section 256B.0625, subdivision  
 56.12 17, paragraph ~~(h)~~ (g), the commissioner of transportation, during the commissioner's  
 56.13 inspection, shall check to ensure the safety provisions contained in that paragraph are in  
 56.14 working order.

56.15 Sec. 2. Minnesota Statutes 2020, section 256.983, is amended to read:

56.16 **256.983 FRAUD PREVENTION INVESTIGATIONS.**

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

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



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

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

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

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

57.33 (b) If, upon investigation, a preponderance of evidence shows a provider committed an  
57.34 intentional program violation, intentionally gave the county or tribe materially false  
57.35 information on the provider's billing forms, provided false attendance records to a county,

58.1 tribe, or the commissioner, or committed financial misconduct as described in section  
 58.2 245E.01, subdivision 8, the county or tribal agency may suspend a provider's payment  
 58.3 pursuant to chapter 245E, or deny or revoke a provider's authorization pursuant to section  
 58.4 119B.13, subdivision 6, paragraph (d), clause (2), prior to pursuing other available remedies.  
 58.5 The county or tribe must send notice in accordance with the requirements of section  
 58.6 119B.161, subdivision 2. If a provider's payment is suspended under this section, the payment  
 58.7 suspension shall remain in effect until: (1) the commissioner, county, tribe, or a law  
 58.8 enforcement authority determines that there is insufficient evidence warranting the action  
 58.9 and a county, tribe, or the commissioner does not pursue an additional administrative remedy  
 58.10 under chapter 119B or 245E, or section 256.046 or 256.98; or (2) all criminal, civil, and  
 58.11 administrative proceedings related to the provider's alleged misconduct conclude and any  
 58.12 appeal rights are exhausted.

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

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

58.20 **Sec. 3. [256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

58.21 (a) Effective January 1, 2023, the commissioner shall contract with up to two dental  
 58.22 administrators to administer dental services for all recipients of medical assistance and  
 58.23 MinnesotaCare, including the administration of dental services for those enrolled in managed  
 58.24 care under section 256B.69.

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

58.27 (1) provider recruitment, contracting, and assistance;

58.28 (2) recipient outreach and assistance;

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

58.30 (4) dental claims processing;

58.31 (5) coordination with other services;

58.32 (6) management of fraud and abuse;

59.1 (7) monitoring of access to dental services;

59.2 (8) performance measurement;

59.3 (9) quality improvement and evaluation requirements; and

59.4 (10) management of third-party liability requirements.

59.5 (c) Payments to contracted dental providers must be at the rates established under section  
59.6 256B.76.

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

59.8 Sec. 4. Minnesota Statutes 2020, section 256B.04, subdivision 12, is amended to read:

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

59.14 ~~The rules shall provide:~~

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

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

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

59.26 ~~(c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective~~  
59.27 ~~on January 1, 1981, "recognized provider of transportation services" means an operator of~~  
59.28 ~~special transportation service as defined in section 174.29 that has been issued a current~~  
59.29 ~~certificate of compliance with operating standards of the commissioner of transportation~~  
59.30 ~~or, if those standards do not apply to the operator, that the agency finds is able to provide~~  
59.31 ~~the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized~~

60.1 ~~transportation provider" includes an operator of special transportation service that the agency~~  
60.2 ~~finds is able to provide the required transportation in a safe and reliable manner.~~

60.3 Sec. 5. Minnesota Statutes 2020, section 256B.04, subdivision 14, is amended to read:

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

60.8 (1) eyeglasses;

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

60.12 (3) hearing aids and supplies; and

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

60.14 (i) hospital beds;

60.15 (ii) commodes;

60.16 (iii) glide-about chairs;

60.17 (iv) patient lift apparatus;

60.18 (v) wheelchairs and accessories;

60.19 (vi) oxygen administration equipment;

60.20 (vii) respiratory therapy equipment;

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

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

60.25 (6) drugs.

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

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

61.1 Sec. 6. Minnesota Statutes 2020, section 256B.0625, subdivision 9, is amended to read:

61.2 Subd. 9. **Dental services.** (a) Medical assistance covers dental services. The commissioner  
61.3 shall contract with a dental administrator for the administration of dental services. The  
61.4 contract shall include the administration of dental services for those enrolled in managed  
61.5 care under section 256B.69.

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

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

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

61.10 (3) limited exams;

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

61.12 (5) periapical x-rays;

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

61.17 (7) prophylaxis, limited to one per year;

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

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

61.20 (10) anterior fillings;

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

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

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

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

61.25 (15) full-mouth debridement, limited to one every five years.

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

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

62.1 (2) general anesthesia; and

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

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

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

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

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

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

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

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

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

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

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

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

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

62.25 Sec. 7. Minnesota Statutes 2020, section 256B.0625, subdivision 17, is amended to read:

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

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

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

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

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

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

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

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

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

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

63.25 (2) the provider has initiated background studies on the individuals specified in section  
63.26 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

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

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

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

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

64.11 ~~(f) Until the commissioner implements the single administrative structure and delivery~~  
 64.12 ~~system under subdivision 18c, clients shall obtain their level-of-service certificate from the~~  
 64.13 ~~commissioner or an entity approved by the commissioner that does not dispatch rides for~~  
 64.14 ~~clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).~~

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

66.4 (3) investigate all complaints and appeals.

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

66.9 ~~(m) (j)~~ Payments for nonemergency medical transportation must be paid based on the  
 66.10 client's assessed mode under paragraph ~~(h)~~ (g), not the type of vehicle used to provide the  
 66.11 service. ~~The medical assistance reimbursement rates for nonemergency medical transportation~~  
 66.12 ~~services that are payable by or on behalf of the commissioner for nonemergency medical~~  
 66.13 ~~transportation services are:~~

66.14 ~~(1) \$0.22 per mile for client reimbursement;~~

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

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

66.20 ~~(4) \$13 for the base rate and \$1.30 per mile for assisted transport;~~

66.21 ~~(5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;~~

66.22 ~~(6) \$75 for the base rate and \$2.40 per mile for protected transport; and~~

66.23 ~~(7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for~~  
 66.24 ~~an additional attendant if deemed medically necessary.~~

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

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

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

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

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

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

67.12 Sec. 8. Minnesota Statutes 2020, section 256B.0625, subdivision 17b, is amended to read:

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

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

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

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

67.26 (3) each entry in the record must document:

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

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

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

67.30 (iv) the signature of the driver attesting to the following: "I certify that I have accurately  
 67.31 reported in this record the trip miles I actually drove and the dates and times I actually drove

68.1 them. I understand that misreporting the miles driven and hours worked is fraud for which  
68.2 I could face criminal prosecution or civil proceedings.";

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

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

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

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

68.10 (ix) whether the service was ambulatory or nonambulatory;

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

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

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

68.16 Sec. 9. Minnesota Statutes 2020, section 256B.0625, subdivision 18b, is amended to read:

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

68.25 Sec. 10. Minnesota Statutes 2020, section 256B.69, subdivision 6d, is amended to read:

68.26 Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude ~~or modify~~ coverage  
68.27 for outpatient prescription drugs dispensed by a pharmacy to a member eligible for medical  
68.28 assistance under this chapter from the prepaid managed care contracts entered into under  
68.29 this section ~~in order to increase savings to the state by collecting additional prescription~~  
68.30 ~~drug rebates. The contracts must maintain incentives for the managed care plan to manage~~  
68.31 ~~drug costs and utilization and may require that the managed care plans maintain an open~~

69.1 ~~drug formulary. In order to manage drug costs and utilization, the contracts may authorize~~  
69.2 ~~the managed care plans to use preferred drug lists and prior authorization. This subdivision~~  
69.3 ~~is contingent on federal approval of the managed care contract changes and the collection~~  
69.4 ~~of additional prescription drug rebates. The commissioner may include, exclude, or modify~~  
69.5 ~~coverage for outpatient prescription drugs dispensed by a pharmacy to a member eligible~~  
69.6 ~~for MinnesotaCare under chapter 256L and prescription drugs administered to a medical~~  
69.7 ~~assistance member or MinnesotaCare member from the prepaid managed care contracts~~  
69.8 ~~entered into under this section.~~

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

69.10 Sec. 11. Minnesota Statutes 2020, section 256B.76, subdivision 2, is amended to read:

69.11 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October  
69.12 1, 1992, the commissioner shall make payments for dental services as follows:

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

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

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

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

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

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

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

69.31 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in  
69.32 paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal year, a

70.1 supplemental state payment equal to the difference between the total payments in paragraph  
70.2 (f) and \$1,850,000 shall be paid from the general fund to state-operated services for the  
70.3 operation of the dental clinics.

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

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

70.12 (j) Effective for services rendered on or after January 1, 2014, payment rates for dental  
70.13 services shall be increased by five percent from the rates in effect on December 31, 2013.  
70.14 This increase does not apply to state-operated dental clinics in paragraph (f), federally  
70.15 qualified health centers, rural health centers, and Indian health services. Effective January  
70.16 1, 2014, payments made to managed care plans and county-based purchasing plans under  
70.17 sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in  
70.18 this paragraph.

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

70.31 (l) Effective for services provided on or after January 1, 2017, through December 31,  
70.32 2022, the commissioner shall increase payment rates by 9.65 percent for dental services  
70.33 provided outside of the seven-county metropolitan area. This increase does not apply to  
70.34 state-operated dental clinics in paragraph (f), federally qualified health centers, rural health

71.1 centers, or Indian health services. Effective January 1, 2017, payments to managed care  
71.2 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect  
71.3 the payment increase described in this paragraph.

71.4 (m) Effective for services provided on or after July 1, 2017, through December 31, 2022,  
71.5 the commissioner shall increase payment rates by 23.8 percent for dental services provided  
71.6 to enrollees under the age of 21. This rate increase does not apply to state-operated dental  
71.7 clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian  
71.8 health centers. This rate increase does not apply to managed care plans and county-based  
71.9 purchasing plans.

71.10 (n) Effective for dental services provided on or after January 1, 2023, the commissioner  
71.11 shall increase payment rates by 54 percent. This rate increase must not apply to state-operated  
71.12 dental clinics in paragraph (f), federally qualified health centers, rural health centers, or  
71.13 Indian health centers.

71.14 Sec. 12. Minnesota Statutes 2020, section 256B.76, subdivision 4, is amended to read:

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

71.23 (b) For dental services rendered on or after July 1, 2016, through December 31, 2022,  
71.24 by a dental clinic or dental group that meets the critical access dental provider designation  
71.25 under paragraph (d), clause (4), and is owned and operated by a health maintenance  
71.26 organization licensed under chapter 62D, the commissioner shall increase reimbursement  
71.27 by 35 percent above the reimbursement rate that would otherwise be paid to the critical  
71.28 access provider.

71.29 (c) Critical access dental payments made under paragraph (a) or (b) for dental services  
71.30 provided by a critical access dental provider to an enrollee of a managed care plan or  
71.31 county-based purchasing plan must not reflect any capitated payments or cost-based payments  
71.32 from the managed care plan or county-based purchasing plan. The managed care plan or  
71.33 county-based purchasing plan must base the additional critical access dental payment on  
71.34 the amount that would have been paid for that service had the dental provider been paid

72.1 according to the managed care plan or county-based purchasing plan's fee schedule that  
72.2 applies to dental providers that are not paid under a capitated payment or cost-based payment.

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

72.5 (1) nonprofit community clinics that:

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

72.7 (ii) have tax exempt status in accordance with the Internal Revenue Code, section  
72.8 501(c)(3);

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

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

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

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

72.16 (vii) have free care available as needed;

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

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

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

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

72.25 (6) private practicing dentists if:

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

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



73.1 Sec. 13. Minnesota Statutes 2020, section 256B.766, is amended to read:

73.2 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

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

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

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

73.19 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,  
73.20 total payments for ambulatory surgery centers facility fees, medical supplies and durable  
73.21 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,  
73.22 renal dialysis services, laboratory services, public health nursing services, physical therapy  
73.23 services, occupational therapy services, speech therapy services, eyeglasses not subject to  
73.24 a volume purchase contract, hearing aids not subject to a volume purchase contract, and  
73.25 anesthesia services shall be reduced by three percent from the rates in effect on August 31,  
73.26 2011.

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

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

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

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

74.17 (i) Effective for services provided on or after July 1, 2015, through June 30, 2021, the  
74.18 following categories of medical supplies and durable medical equipment shall be individually  
74.19 priced items: enteral nutrition and supplies, customized and other specialized tracheostomy  
74.20 tubes and supplies, electric patient lifts, and durable medical equipment repair and service.  
74.21 This paragraph does not apply to medical supplies and durable medical equipment subject  
74.22 to a volume purchase contract, products subject to the preferred diabetic testing supply  
74.23 program, and items provided to dually eligible recipients when Medicare is the primary  
74.24 payer for the item. The commissioner shall not apply any medical assistance rate reductions  
74.25 to durable medical equipment as a result of Medicare competitive bidding through June 30,  
74.26 2021.

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

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

74.33 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on  
74.34 the medical assistance fee schedule, whether or not subject to the Medicare competitive bid

75.1 that took effect in January of 2009, shall be increased by 2.94 percent, with this increase  
75.2 being applied after calculation of any increased payment rate under clause (1).

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

75.9 (k) Effective for nonpressure support ventilators provided on or after January 1, 2016,  
75.10 through June 30, 2021, the rate shall be the lower of the submitted charge or the Medicare  
75.11 fee schedule rate. Effective for pressure support ventilators provided on or after January 1,  
75.12 2016, through June 30, 2021, the rate shall be the lower of the submitted charge or 47 percent  
75.13 above the Medicare fee schedule rate. For payments made in accordance with this paragraph,  
75.14 if, and to the extent that, the commissioner identifies that the state has received federal  
75.15 financial participation for ventilators in excess of the amount allowed effective January 1,  
75.16 2018, under United States Code, title 42, section 1396b(i)(27), the state shall repay the  
75.17 excess amount to the Centers for Medicare and Medicaid Services with state funds and  
75.18 maintain the full payment rate under this paragraph.

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

75.23 (m) Effective July 1, 2021, the payment rates for all durable medical equipment,  
75.24 prosthetics, orthotics, or supplies shall be the lesser of the provider's submitted charges or  
75.25 the Medicare fee schedule amount, with no increases or decreases described in paragraphs  
75.26 (a) to (k) applied.

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

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

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

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

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

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

76.13 (4) Not more than once every three years, the alternate payment methodology rates must  
76.14 be evaluated by the commissioner for reasonableness by reviewing invoices from at least  
76.15 20 paid claim lines and five different providers for claims paid during one calendar month  
76.16 or one quarter if necessary to obtain the required sample. If the evaluation identifies that  
76.17 the alternate payment methodology rate is more than five percent higher or lower than the  
76.18 provider's actual acquisition cost plus 20 percent, then the commissioner shall recalculate  
76.19 and update the fee schedule according to clauses (1) to (3). If the evaluation does not show  
76.20 that the alternate payment methodology fee schedule rate is five percent higher or lower  
76.21 than the provider's actual acquisition cost plus 20 percent or a sufficient sample cannot be  
76.22 collected due to low utilization as defined in clause (1), then the commissioner shall maintain  
76.23 the previously calculated alternate payment methodology rate on the fee schedule.

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

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

77.1 Sec. 14. Minnesota Statutes 2020, section 256B.767, is amended to read:

77.2 **256B.767 MEDICARE PAYMENT LIMIT.**

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

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

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

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

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

77.23 Sec. 15. Minnesota Statutes 2020, section 256L.11, subdivision 7, is amended to read:

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

78.1 Sec. 16. **REPEALER.**

78.2 Minnesota Statutes 2020, sections 256B.0625, subdivisions 18c, 18d, 18e, and 18h; and  
 78.3 256L.11, subdivision 6a, are repealed.

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

78.5 **ARTICLE 4**

78.6 **HEALTH AND HEALTH-BOARD APPROPRIATIONS**

78.7 Section 1. **APPROPRIATIONS.**

78.8 The sums shown in the columns marked "Appropriations" are appropriated to the agencies  
 78.9 and for the purposes specified in this article. The appropriations are from the general fund,  
 78.10 or another named fund, and are available for the fiscal years indicated for each purpose.  
 78.11 The figures "2022" and "2023" used in this article mean that the appropriations listed under  
 78.12 them are available for the fiscal year ending June 30, 2022, or June 30, 2023, respectively.  
 78.13 "The first year" is fiscal year 2022. "The second year" is fiscal year 2023. "The biennium"  
 78.14 is fiscal years 2022 and 2023.

78.15 **APPROPRIATIONS**

78.16 **Available for the Year**

78.17 **Ending June 30**

78.18 **2022** **2023**

78.19 Sec. 2. **COMMISSIONER OF HEALTH**

78.20 **Subdivision 1. Total Appropriation** **\$ 250,023,000** **\$ 249,704,000**

78.21 **Appropriations by Fund**

|                                 | <u>2022</u>        | <u>2023</u>        |
|---------------------------------|--------------------|--------------------|
| 78.23 <u>General</u>            | <u>132,347,000</u> | <u>132,324,000</u> |
| 78.24 <u>State Government</u>   |                    |                    |
| 78.25 <u>Special Revenue</u>    | <u>68,451,000</u>  | <u>68,835,000</u>  |
| 78.26 <u>Health Care Access</u> | <u>37,512,000</u>  | <u>36,832,000</u>  |
| 78.27 <u>Federal TANF</u>       | <u>11,713,000</u>  | <u>11,713,000</u>  |

78.28 The amounts that may be spent for each  
 78.29 purpose are specified in the following  
 78.30 subdivisions.

78.31 **Subd. 2. Health Improvement**

|       |  |                                     |
|-------|--|-------------------------------------|
| 79.1  | <u>Appropriations by Fund</u>                          |                                     |
| 79.2  | <u>General</u>   | <u>95,690,000</u> <u>95,877,000</u> |
| 79.3  | <u>State Government</u>                                |                                     |
| 79.4  | <u>Special Revenue</u>                                 | <u>9,140,000</u> <u>9,140,000</u>   |
| 79.5  | <u>Health Care Access</u>                              | <u>37,512,000</u> <u>36,832,000</u> |
| 79.6  | <u>Federal TANF</u>                                    | <u>11,713,000</u> <u>11,713,000</u> |
| 79.7  | <u>(a) TANF Appropriations. (1) \$3,579,000 in</u>     |                                     |
| 79.8  | <u>fiscal year 2022 and \$3,579,000 in fiscal year</u> |                                     |
| 79.9  | <u>2023 are from the TANF fund for home</u>            |                                     |
| 79.10 | <u>visiting and nutritional services listed under</u>  |                                     |
| 79.11 | <u>Minnesota Statutes, section 145.882,</u>            |                                     |
| 79.12 | <u>subdivision 7, clauses (6) and (7). Funds must</u>  |                                     |
| 79.13 | <u>be distributed to community health boards</u>       |                                     |
| 79.14 | <u>according to Minnesota Statutes, section</u>        |                                     |
| 79.15 | <u>145A.131, subdivision 1;</u>                        |                                     |
| 79.16 | <u>(2) \$2,000,000 in fiscal year 2022 and</u>         |                                     |
| 79.17 | <u>\$2,000,000 in fiscal year 2023 are from the</u>    |                                     |
| 79.18 | <u>TANF fund for decreasing racial and ethnic</u>      |                                     |
| 79.19 | <u>disparities in infant mortality rates under</u>     |                                     |
| 79.20 | <u>Minnesota Statutes, section 145.928,</u>            |                                     |
| 79.21 | <u>subdivision 7;</u>                                  |                                     |
| 79.22 | <u>(3) \$4,978,000 in fiscal year 2022 and</u>         |                                     |
| 79.23 | <u>\$4,978,000 in fiscal year 2023 are from the</u>    |                                     |
| 79.24 | <u>TANF fund for the family home visiting grant</u>    |                                     |
| 79.25 | <u>program according to Minnesota Statutes,</u>        |                                     |
| 79.26 | <u>section 145A.17. \$4,000,000 of the funding</u>     |                                     |
| 79.27 | <u>in each fiscal year must be distributed to</u>      |                                     |
| 79.28 | <u>community health boards according to</u>            |                                     |
| 79.29 | <u>Minnesota Statutes, section 145A.131,</u>           |                                     |
| 79.30 | <u>subdivision 1. \$978,000 of the funding in each</u> |                                     |
| 79.31 | <u>fiscal year must be distributed to tribal</u>       |                                     |
| 79.32 | <u>governments according to Minnesota Statutes,</u>    |                                     |
| 79.33 | <u>section 145A.14, subdivision 2a;</u>                |                                     |
| 79.34 | <u>(4) \$1,156,000 in fiscal year 2022 and</u>         |                                     |
| 79.35 | <u>\$1,156,000 in fiscal year 2023 are from the</u>    |                                     |

80.1 TANF fund for family planning grants under  
80.2 Minnesota Statutes, section 145.925; and  
80.3 (5) the commissioner may use up to 6.23  
80.4 percent of the funds appropriated from the  
80.5 TANF fund each fiscal year to conduct the  
80.6 ongoing evaluations required under Minnesota  
80.7 Statutes, section 145A.17, subdivision 7, and  
80.8 training and technical assistance as required  
80.9 under Minnesota Statutes, section 145A.17,  
80.10 subdivisions 4 and 5.

80.11 **(b) TANF Carryforward.** Any unexpended  
80.12 balance of the TANF appropriation in the first  
80.13 year of the biennium does not cancel but is  
80.14 available for the second year.

80.15 **(c) Fetal and Infant Mortality Review.**  
80.16 \$311,000 in fiscal year 2022 and \$311,000 in  
80.17 fiscal year 2023 are appropriated from the  
80.18 general fund to the commissioner of health to  
80.19 be used to conduct fetal and infant mortality  
80.20 reviews under Minnesota Statutes, section  
80.21 145.9011.

80.22 **(d) Maternal Morbidity and Death Studies.**  
80.23 \$198,000 in fiscal year 2022 and \$198,000 in  
80.24 fiscal year 2023 are appropriated from the  
80.25 general fund to the commissioner of health to  
80.26 be used to conduct maternal morbidity and  
80.27 death studies under Minnesota Statutes,  
80.28 section 145.901.

80.29 **(e) Transfer.** The \$77,000 transfer each year  
80.30 from the state government special revenue  
80.31 fund to the general fund as required by Laws  
80.32 2008, chapter 364, section 17, paragraph (b),  
80.33 is canceled effective June 30, 2021.



81.1 (f) **MERC Program.** The general fund  
 81.2 appropriation for distribution via the Medical  
 81.3 Education and Research Cost formula under  
 81.4 Minnesota Statutes, section 62J.692,  
 81.5 subdivision 4, is \$0 in fiscal years 2022 and  
 81.6 2023.

81.7 (g) **Base Level Adjustments.** The general  
 81.8 fund base is \$94,877,000 in fiscal year 2024  
 81.9 and \$94,877,000 in fiscal year 2025. The state  
 81.10 government special revenue fund base is  
 81.11 \$9,140,000 in fiscal year 2024 and \$9,140,000  
 81.12 in fiscal year 2025. The health care access  
 81.13 fund base is \$37,432,000 in fiscal year 2024  
 81.14 and \$36,832,000 in fiscal year 2025.

81.15 Subd. 3. **Health Protection**

|       |                               |                   |                   |
|-------|-------------------------------|-------------------|-------------------|
| 81.16 | <u>Appropriations by Fund</u> |                   |                   |
| 81.17 | <u>General</u>                | <u>25,087,000</u> | <u>24,868,000</u> |
| 81.18 | <u>State Government</u>       |                   |                   |
| 81.19 | <u>Special Revenue</u>        | <u>59,311,000</u> | <u>59,695,000</u> |

81.20 **Base Level Adjustments.** The general fund  
 81.21 base is \$24,868,000 in fiscal year 2024 and  
 81.22 \$24,868,000 in fiscal year 2025. The state  
 81.23 government special revenue fund base is  
 81.24 \$59,695,000 in fiscal year 2024 and  
 81.25 \$59,695,000 in fiscal year 2025.

81.26 Subd. 4. **Health Operations** 11,570,000 11,579,000

81.27 Sec. 3. **HEALTH-RELATED BOARDS**

81.28 Subdivision 1. **Total Appropriation** \$ 27,507,000 \$ 26,943,000

|       |                               |                   |                   |
|-------|-------------------------------|-------------------|-------------------|
| 81.29 | <u>Appropriations by Fund</u> |                   |                   |
| 81.30 | <u>State Government</u>       |                   |                   |
| 81.31 | <u>Special Revenue</u>        | <u>27,431,000</u> | <u>26,867,000</u> |
| 81.32 | <u>Health Care Access</u>     | <u>76,000</u>     | <u>76,000</u>     |

81.33 This appropriation is from the state  
 81.34 government special revenue fund unless

82.1 specified otherwise. The amounts that may be  
 82.2 spent for each purpose are specified in the  
 82.3 following subdivisions.

|      |  |                |                |
|------|--|----------------|----------------|
| 82.4 | <u>Subd. 2. <b>Board of Chiropractic Examiners</b></u> | <u>666,000</u> | <u>666,000</u> |
|------|--|----------------|----------------|

|      |   |                  |                  |
|------|---|------------------|------------------|
| 82.5 | <u>Subd. 3. <b>Board of Dentistry</b></u> | <u>4,228,000</u> | <u>3,753,000</u> |
|------|---|------------------|------------------|

82.6 (a) **Administrative Services Unit - Operating**  
 82.7 **Costs.** Of this appropriation, \$2,738,000 in  
 82.8 fiscal year 2022 and \$2,263,000 in fiscal year  
 82.9 2023 are for operating costs of the  
 82.10 administrative services unit. The  
 82.11 administrative services unit may receive and  
 82.12 expend reimbursements for services it  
 82.13 performs for other agencies.

82.14 (b) **Administrative Services Unit - Volunteer**  
 82.15 **Health Care Provider Program.** Of this  
 82.16 appropriation, \$150,000 in fiscal year 2022  
 82.17 and \$150,000 in fiscal year 2023 are to pay  
 82.18 for medical professional liability coverage  
 82.19 required under Minnesota Statutes, section  
 82.20 214.40.

82.21 (c) **Administrative Services Unit -**  
 82.22 **Retirement Costs.** Of this appropriation,  
 82.23 \$475,000 in fiscal year 2022 is a onetime  
 82.24 appropriation to the administrative services  
 82.25 unit to pay for the retirement costs of  
 82.26 health-related board employees. This funding  
 82.27 may be transferred to the health board  
 82.28 incurring retirement costs. Any board that has  
 82.29 an unexpended balance for an amount  
 82.30 transferred under this paragraph shall transfer  
 82.31 the unexpended amount to the administrative  
 82.32 services unit. These funds are available either  
 82.33 year of the biennium.

83.1 **(d) Administrative Services Unit - Contested**  
 83.2 **Cases and Other Legal Proceedings.** Of this  
 83.3 appropriation, \$200,000 in fiscal year 2022  
 83.4 and \$200,000 in fiscal year 2023 are for costs  
 83.5 of contested case hearings and other  
 83.6 unanticipated costs of legal proceedings  
 83.7 involving health-related boards funded under  
 83.8 this section. Upon certification by a  
 83.9 health-related board to the administrative  
 83.10 services unit that costs will be incurred and  
 83.11 that there is insufficient money available to  
 83.12 pay for the costs out of money currently  
 83.13 available to that board, the administrative  
 83.14 services unit is authorized to transfer money  
 83.15 from this appropriation to the board for  
 83.16 payment of those costs with the approval of  
 83.17 the commissioner of management and budget.  
 83.18 The commissioner of management and budget  
 83.19 must require any board that has an unexpended  
 83.20 balance for an amount transferred under this  
 83.21 paragraph to transfer the unexpended amount  
 83.22 to the administrative services unit to be  
 83.23 deposited in the state government special  
 83.24 revenue fund.

83.25 **Subd. 4. Board of Dietetics and Nutrition**  
 83.26 **Practice**

164,000

164,000

83.27 **Subd. 5. Board of Marriage and Family Therapy**

406,000

406,000

83.28 **Subd. 6. Board of Medical Practice**

5,912,000

5,868,000

83.29 **Health Professional Services Program.** This  
 83.30 appropriation includes \$1,002,000 in fiscal  
 83.31 year 2022 and \$1,002,000 in fiscal year 2023  
 83.32 for the health professional services program.

83.33 **Subd. 7. Board of Nursing**

5,345,000

5,355,000

83.34 **Subd. 8. Board of Executives for Long Term**  
 83.35 **Services and Supports**

693,000

635,000

|       |  |                  |                     |                     |
|-------|--|------------------|---------------------|---------------------|
| 84.1  | <u>Subd. 9. Board of Optometry</u>                       |                  | <u>238,000</u>      | <u>238,000</u>      |
| 84.2  | <u>Subd. 10. Board of Pharmacy</u>                       |                  | <u>4,479,000</u>    | <u>4,479,000</u>    |
| 84.3  | <u>Appropriations by Fund</u>                            |                  |                     |                     |
| 84.4  | <u>State Government</u>                                  |                  |                     |                     |
| 84.5  | <u>Special Revenue</u>                                   | <u>4,403,000</u> | <u>4,403,000</u>    |                     |
| 84.6  | <u>Health Care Access</u>                                | <u>76,000</u>    | <u>76,000</u>       |                     |
| 84.7  | <u>The base for this appropriation in the health</u>     |                  |                     |                     |
| 84.8  | <u>care access fund is \$76,000 in fiscal year 2024,</u> |                  |                     |                     |
| 84.9  | <u>\$38,000 in fiscal year 2025, and \$0 in fiscal</u>   |                  |                     |                     |
| 84.10 | <u>year 2026.</u>  |                  |                     |                     |
| 84.11 | <u>Subd. 11. Board of Physical Therapy</u>               |                  | <u>564,000</u>      | <u>564,000</u>      |
| 84.12 | <u>Subd. 12. Board of Podiatric Medicine</u>             |                  | <u>214,000</u>      | <u>214,000</u>      |
| 84.13 | <u>Subd. 13. Board of Psychology</u>                     |                  | <u>1,355,000</u>    | <u>1,355,000</u>    |
| 84.14 | <u>Subd. 14. Board of Social Work</u>                    |                  | <u>1,556,000</u>    | <u>1,559,000</u>    |
| 84.15 | <u>Subd. 15. Board of Veterinary Medicine</u>            |                  | <u>363,000</u>      | <u>363,000</u>      |
| 84.16 | <u>Subd. 16. Board of Behavioral Health and</u>          |                  |                     |                     |
| 84.17 | <u>Therapy</u>   |                  |                     |                     |
| 84.18 | <u>Subd. 17. Board of Occupational Therapy</u>           |                  |                     |                     |
| 84.19 | <u>Practice</u>  |                  |                     |                     |
| 84.20 | <u>Sec. 4. EMERGENCY MEDICAL SERVICES</u>                |                  |                     |                     |
| 84.21 | <u>REGULATORY BOARD</u>                                  |                  |                     |                     |
|       |  |                  | <u>\$ 3,803,000</u> | <u>\$ 3,829,000</u> |
| 84.22 | <u>(a) Cooper/Sams Volunteer Ambulance</u>               |                  |                     |                     |
| 84.23 | <u>Program. \$950,000 in fiscal year 2022 and</u>        |                  |                     |                     |
| 84.24 | <u>\$950,000 in fiscal year 2023 are for the</u>         |                  |                     |                     |
| 84.25 | <u>Cooper/Sams volunteer ambulance program</u>           |                  |                     |                     |
| 84.26 | <u>under Minnesota Statutes, section 144E.40.</u>        |                  |                     |                     |
| 84.27 | <u>(1) Of this amount, \$861,000 in fiscal year</u>      |                  |                     |                     |
| 84.28 | <u>2022 and \$861,000 in fiscal year 2023 are for</u>    |                  |                     |                     |
| 84.29 | <u>the ambulance service personnel longevity</u>         |                  |                     |                     |
| 84.30 | <u>award and incentive program under Minnesota</u>       |                  |                     |                     |
| 84.31 | <u>Statutes, section 144E.40.</u>                        |                  |                     |                     |
| 84.32 | <u>(2) Of this amount, \$89,000 in fiscal year 2022</u>  |                  |                     |                     |
| 84.33 | <u>and \$89,000 in fiscal year 2023 are for the</u>      |                  |                     |                     |

85.1 operations of the ambulance service personnel  
 85.2 longevity award and incentive program under  
 85.3 Minnesota Statutes, section 144E.40.

85.4 (b) EMSRB Operations. \$1,880,000 in fiscal  
 85.5 year 2022 and \$1,880,000 in fiscal year 2023  
 85.6 are for board operations.

85.7 (c) Regional Grants. \$585,000 in fiscal year  
 85.8 2022 and \$585,000 in fiscal year 2023 are for  
 85.9 regional emergency medical services  
 85.10 programs, to be distributed equally to the eight  
 85.11 emergency medical service regions under  
 85.12 Minnesota Statutes, section 144E.52.

85.13 (d) Ambulance Training Grant. \$361,000  
 85.14 in fiscal year 2022 and \$361,000 in fiscal year  
 85.15 2023 are for training grants under Minnesota  
 85.16 Statutes, section 144E.35.

85.17 Sec. 5. COUNCIL ON DISABILITY \$ 1,022,000 \$ 1,038,000

85.18 Sec. 6. OMBUDSMAN FOR MENTAL  
 85.19 HEALTH AND DEVELOPMENTAL  
 85.20 DISABILITIES \$ 2,487,000 \$ 2,536,000

85.21 Department of Psychiatry Monitoring.  
 85.22 \$100,000 in fiscal year 2022 and \$100,000 in  
 85.23 fiscal year 2023 are for monitoring the  
 85.24 Department of Psychiatry at the University of  
 85.25 Minnesota.

85.26 Sec. 7. OMBUDSPERSONS FOR FAMILIES \$ 733,000 \$ 744,000

85.27 Sec. 8. Laws 2019, First Special Session chapter 9, article 14, section 3, as amended by  
 85.28 Laws 2019, First Special Session chapter 12, section 6, is amended to read:

85.29 Sec. 3. **COMMISSIONER OF HEALTH**

85.30 236,188,000  
 85.31 Subdivision 1. **Total Appropriation** \$ 231,829,000 \$ 233,979,000

85.32 Appropriations by Fund  
 85.33 2020 2021

|      |                    |             |                       |
|------|--------------------|-------------|-----------------------|
| 86.1 | General            | 124,381,000 | 126,276,000           |
| 86.2 | State Government   |             | <del>61,367,000</del> |
| 86.3 | Special Revenue    | 58,450,000  | <u>59,158,000</u>     |
| 86.4 | Health Care Access | 37,285,000  | 36,832,000            |
| 86.5 | Federal TANF       | 11,713,000  | 11,713,000            |

86.6 The amounts that may be spent for each  
86.7 purpose are specified in the following  
86.8 subdivisions.

86.9 **Subd. 2. Health Improvement**

86.10 Appropriations by Fund

|       |                    |            |                      |
|-------|--------------------|------------|----------------------|
| 86.11 | General            | 94,980,000 | 96,117,000           |
| 86.12 | State Government   |            | <del>7,558,000</del> |
| 86.13 | Special Revenue    | 7,614,000  | <u>6,924,000</u>     |
| 86.14 | Health Care Access | 37,285,000 | 36,832,000           |
| 86.15 | Federal TANF       | 11,713,000 | 11,713,000           |

86.16 **(a) TANF Appropriations.** (1) \$3,579,000 in  
86.17 fiscal year 2020 and \$3,579,000 in fiscal year  
86.18 2021 are from the TANF fund for home  
86.19 visiting and nutritional services under  
86.20 Minnesota Statutes, section 145.882,  
86.21 subdivision 7, clauses (6) and (7). Funds must  
86.22 be distributed to community health boards  
86.23 according to Minnesota Statutes, section  
86.24 145A.131, subdivision 1;

86.25 (2) \$2,000,000 in fiscal year 2020 and  
86.26 \$2,000,000 in fiscal year 2021 are from the  
86.27 TANF fund for decreasing racial and ethnic  
86.28 disparities in infant mortality rates under  
86.29 Minnesota Statutes, section 145.928,  
86.30 subdivision 7;

86.31 (3) \$4,978,000 in fiscal year 2020 and  
86.32 \$4,978,000 in fiscal year 2021 are from the  
86.33 TANF fund for the family home visiting grant  
86.34 program under Minnesota Statutes, section  
86.35 145A.17. \$4,000,000 of the funding in each

87.1 fiscal year must be distributed to community  
87.2 health boards according to Minnesota Statutes,  
87.3 section 145A.131, subdivision 1. \$978,000 of  
87.4 the funding in each fiscal year must be  
87.5 distributed to tribal governments according to  
87.6 Minnesota Statutes, section 145A.14,  
87.7 subdivision 2a;

87.8 (4) \$1,156,000 in fiscal year 2020 and  
87.9 \$1,156,000 in fiscal year 2021 are from the  
87.10 TANF fund for family planning grants under  
87.11 Minnesota Statutes, section 145.925; and

87.12 (5) The commissioner may use up to 6.23  
87.13 percent of the amounts appropriated from the  
87.14 TANF fund each year to conduct the ongoing  
87.15 evaluations required under Minnesota Statutes,  
87.16 section 145A.17, subdivision 7, and training  
87.17 and technical assistance as required under  
87.18 Minnesota Statutes, section 145A.17,  
87.19 subdivisions 4 and 5.

87.20 **(b) TANF Carryforward.** Any unexpended  
87.21 balance of the TANF appropriation in the first  
87.22 year of the biennium does not cancel but is  
87.23 available for the second year.

87.24 **(c) Comprehensive Suicide Prevention.**  
87.25 \$2,730,000 in fiscal year 2020 and \$2,730,000  
87.26 in fiscal year 2021 are from the general fund  
87.27 for a comprehensive, community-based suicide  
87.28 prevention strategy. The funds are allocated  
87.29 as follows:

87.30 (1) \$955,000 in fiscal year 2020 and \$955,000  
87.31 in fiscal year 2021 are for community-based  
87.32 suicide prevention grants authorized in  
87.33 Minnesota Statutes, section 145.56,  
87.34 subdivision 2. Specific emphasis must be

88.1 placed on those communities with the greatest  
88.2 disparities. The base for this appropriation is  
88.3 \$1,291,000 in fiscal year 2022 and \$1,291,000  
88.4 in fiscal year 2023;

88.5 (2) \$683,000 in fiscal year 2020 and \$683,000  
88.6 in fiscal year 2021 are to support  
88.7 evidence-based training for educators and  
88.8 school staff and purchase suicide prevention  
88.9 curriculum for student use statewide, as  
88.10 authorized in Minnesota Statutes, section  
88.11 145.56, subdivision 2. The base for this  
88.12 appropriation is \$913,000 in fiscal year 2022  
88.13 and \$913,000 in fiscal year 2023;

88.14 (3) \$137,000 in fiscal year 2020 and \$137,000  
88.15 in fiscal year 2021 are to implement the Zero  
88.16 Suicide framework with up to 20 behavioral  
88.17 and health care organizations each year to treat  
88.18 individuals at risk for suicide and support  
88.19 those individuals across systems of care upon  
88.20 discharge. The base for this appropriation is  
88.21 \$205,000 in fiscal year 2022 and \$205,000 in  
88.22 fiscal year 2023;

88.23 (4) \$955,000 in fiscal year 2020 and \$955,000  
88.24 in fiscal year 2021 are to develop and fund a  
88.25 Minnesota-based network of National Suicide  
88.26 Prevention Lifeline, providing statewide  
88.27 coverage. The base for this appropriation is  
88.28 \$1,321,000 in fiscal year 2022 and \$1,321,000  
88.29 in fiscal year 2023; and

88.30 (5) the commissioner may retain up to 18.23  
88.31 percent of the appropriation under this  
88.32 paragraph to administer the comprehensive  
88.33 suicide prevention strategy.



89.1 **(d) Statewide Tobacco Cessation.** \$1,598,000  
89.2 in fiscal year 2020 and \$2,748,000 in fiscal  
89.3 year 2021 are from the general fund for  
89.4 statewide tobacco cessation services under  
89.5 Minnesota Statutes, section 144.397. The base  
89.6 for this appropriation is \$2,878,000 in fiscal  
89.7 year 2022 and \$2,878,000 in fiscal year 2023.

89.8 **(e) Health Care Access Survey.** \$225,000 in  
89.9 fiscal year 2020 and \$225,000 in fiscal year  
89.10 2021 are from the health care access fund to  
89.11 continue and improve the Minnesota Health  
89.12 Care Access Survey. These appropriations  
89.13 may be used in either year of the biennium.

89.14 **(f) Community Solutions for Healthy Child**  
89.15 **Development Grant Program.** \$1,000,000  
89.16 in fiscal year 2020 and \$1,000,000 in fiscal  
89.17 year 2021 are for the community solutions for  
89.18 healthy child development grant program to  
89.19 promote health and racial equity for young  
89.20 children and their families under article 11,  
89.21 section 107. The commissioner may use up to  
89.22 23.5 percent of the total appropriation for  
89.23 administration. The base for this appropriation  
89.24 is \$1,000,000 in fiscal year 2022, \$1,000,000  
89.25 in fiscal year 2023, and \$0 in fiscal year 2024.

89.26 **(g) Domestic Violence and Sexual Assault**  
89.27 **Prevention Program.** \$375,000 in fiscal year  
89.28 2020 and \$375,000 in fiscal year 2021 are  
89.29 from the general fund for the domestic  
89.30 violence and sexual assault prevention  
89.31 program under article 11, section 108. This is  
89.32 a onetime appropriation.

89.33 **(h) Skin Lightening Products Public**  
89.34 **Awareness Grant Program.** \$100,000 in  
89.35 fiscal year 2020 and \$100,000 in fiscal year

90.1 2021 are from the general fund for a skin  
 90.2 lightening products public awareness and  
 90.3 education grant program. This is a onetime  
 90.4 appropriation.

90.5 **(i) Cannabinoid Products Workgroup.**  
 90.6 \$8,000 in fiscal year 2020 is from the state  
 90.7 government special revenue fund for the  
 90.8 cannabinoid products workgroup. This is a  
 90.9 onetime appropriation.

90.10 **(j) Base Level Adjustments.** The general fund  
 90.11 base is \$96,742,000 in fiscal year 2022 and  
 90.12 \$96,742,000 in fiscal year 2023. The health  
 90.13 care access fund base is \$37,432,000 in fiscal  
 90.14 year 2022 and \$36,832,000 in fiscal year 2023.

90.15 **Subd. 3. Health Protection**

| 90.16 Appropriations by Fund |                  |            |                       |
|------------------------------|------------------|------------|-----------------------|
| 90.17                        | General          | 18,803,000 | 19,774,000            |
| 90.18                        | State Government |            | <del>53,809,000</del> |
| 90.19                        | Special Revenue  | 50,836,000 | <u>52,234,000</u>     |

90.20 **(a) Public Health Laboratory Equipment.**  
 90.21 \$840,000 in fiscal year 2020 and \$655,000 in  
 90.22 fiscal year 2021 are from the general fund for  
 90.23 equipment for the public health laboratory.  
 90.24 This is a onetime appropriation and is  
 90.25 available until June 30, 2023.

90.26 **(b) Base Level Adjustment.** The general fund  
 90.27 base is \$19,119,000 in fiscal year 2022 and  
 90.28 \$19,119,000 in fiscal year 2023. The state  
 90.29 government special revenue fund base is  
 90.30 \$53,782,000 in fiscal year 2022 and  
 90.31 \$53,782,000 in fiscal year 2023.

91.1 Subd. 4. **Health Operations** 10,598,000 10,385,000

91.2 **Base Level Adjustment.** The general fund  
91.3 base is \$10,912,000 in fiscal year 2022 and  
91.4 \$10,912,000 in fiscal year 2023.

91.5 **EFFECTIVE DATE.** This section is effective the day following final enactment and  
91.6 the reductions in subdivisions 1 to 3 are onetime reductions.

91.7 Sec. 9. **TRANSFERS; HEALTH.**

91.8 Positions, salary money, and nonsalary administrative money may be transferred within  
91.9 the Department of Health as the commissioner considers necessary, with the advance  
91.10 approval of the commissioner of management and budget. The commissioner shall inform  
91.11 the chairs and ranking minority members of the legislative committees with jurisdiction  
91.12 over health and human services finance quarterly about transfers made under this section.

91.13 Sec. 10. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

91.14 The commissioner of health shall not use indirect cost allocations to pay for the  
91.15 operational costs of any program for which they are responsible.

91.16 Sec. 11. **EXPIRATION OF UNCODIFIED LANGUAGE.**

91.17 All uncodified language contained in this article expires on June 30, 2023, unless a  
91.18 different expiration date is explicit.

91.19 Sec. 12. **EFFECTIVE DATE.**

91.20 This article is effective July 1, 2021, unless a different effective date is specified.

91.21 **ARTICLE 5**

91.22 **HEALTH POLICY**

91.23 Section 1. Minnesota Statutes 2020, section 62J.495, subdivision 1, is amended to read:

91.24 Subdivision 1. **Implementation.** The commissioner of health, in consultation with the  
91.25 e-Health Advisory Committee, shall develop uniform standards to be used for the  
91.26 interoperable electronic health records system for sharing and synchronizing patient data  
91.27 across systems. The standards must be compatible with federal efforts. The uniform standards  
91.28 must be developed by January 1, 2009, and updated on an ongoing basis. ~~The commissioner~~  
91.29 ~~shall include an update on standards development as part of an annual report to the legislature.~~

92.1 Individual health care providers in private practice with no other providers and health care  
92.2 providers that do not accept reimbursement from a group purchaser, as defined in section  
92.3 62J.03, subdivision 6, are excluded from the requirements of this section.

92.4 Sec. 2. Minnesota Statutes 2020, section 62J.495, subdivision 2, is amended to read:

92.5 Subd. 2. **E-Health Advisory Committee.** (a) The commissioner shall establish an  
92.6 e-Health Advisory Committee governed by section 15.059 to advise the commissioner on  
92.7 the following matters:

92.8 (1) assessment of the adoption and effective use of health information technology by  
92.9 the state, licensed health care providers and facilities, and local public health agencies;

92.10 (2) recommendations for implementing a statewide interoperable health information  
92.11 infrastructure, to include estimates of necessary resources, and for determining standards  
92.12 for clinical data exchange, clinical support programs, patient privacy requirements, and  
92.13 maintenance of the security and confidentiality of individual patient data;

92.14 (3) recommendations for encouraging use of innovative health care applications using  
92.15 information technology and systems to improve patient care and reduce the cost of care,  
92.16 including applications relating to disease management and personal health management  
92.17 that enable remote monitoring of patients' conditions, especially those with chronic  
92.18 conditions; and

92.19 (4) other related issues as requested by the commissioner.

92.20 (b) The members of the e-Health Advisory Committee shall include the commissioners,  
92.21 or commissioners' designees, of health, human services, administration, and commerce and  
92.22 additional members to be appointed by the commissioner to include persons representing  
92.23 Minnesota's local public health agencies, licensed hospitals and other licensed facilities and  
92.24 providers, private purchasers, the medical and nursing professions, health insurers and health  
92.25 plans, the state quality improvement organization, academic and research institutions,  
92.26 consumer advisory organizations with an interest and expertise in health information  
92.27 technology, and other stakeholders as identified by the commissioner to fulfill the  
92.28 requirements of section 3013, paragraph (g), of the HITECH Act.

92.29 ~~(c) The commissioner shall prepare and issue an annual report not later than January 30~~  
92.30 ~~of each year outlining progress to date in implementing a statewide health information~~  
92.31 ~~infrastructure and recommending action on policy and necessary resources to continue the~~  
92.32 ~~promotion of adoption and effective use of health information technology.~~

92.33 ~~(d)~~ This subdivision expires June 30, 2021.

93.1 Sec. 3. Minnesota Statutes 2020, section 62J.495, subdivision 3, is amended to read:

93.2 Subd. 3. **Interoperable electronic health record requirements.** (a) Hospitals and health  
93.3 care providers must meet the following criteria when implementing an interoperable  
93.4 electronic health records system within their hospital system or clinical practice setting.

93.5 (b) The electronic health record must be a qualified electronic health record.

93.6 (c) The electronic health record must be certified by the Office of the National  
93.7 Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health  
93.8 care providers if a certified electronic health record product for the provider's particular  
93.9 practice setting is available. This criterion shall be considered met if a hospital or health  
93.10 care provider is using an electronic health records system that has been certified within the  
93.11 last three years, even if a more current version of the system has been certified within the  
93.12 three-year period.

93.13 (d) The electronic health record must meet the standards established according to section  
93.14 3004 of the HITECH Act as applicable.

93.15 (e) The electronic health record must have the ability to generate information on clinical  
93.16 quality measures and other measures reported under sections 4101, 4102, and 4201 of the  
93.17 HITECH Act.

93.18 (f) The electronic health record system must be connected to a state-certified health  
93.19 information organization either directly or through a connection facilitated by a ~~state-certified~~  
93.20 health data intermediary as defined in section 62J.498.

93.21 (g) A health care provider who is a prescriber or dispenser of legend drugs must have  
93.22 an electronic health record system that meets the requirements of section 62J.497.

93.23 Sec. 4. Minnesota Statutes 2020, section 62J.495, subdivision 4, is amended to read:

93.24 Subd. 4. **Coordination with national HIT activities.** (a) The commissioner, in  
93.25 consultation with the e-Health Advisory Committee, shall update the statewide  
93.26 implementation plan required under subdivision 2 and released June 2008, to be consistent  
93.27 with the updated federal HIT Strategic Plan released by the Office of the National Coordinator  
93.28 ~~in accordance with section 3001 of the HITECH Act. The statewide plan shall meet the~~  
93.29 ~~requirements for a plan required under section 3013 of the HITECH Act~~ plans.

93.30 (b) The commissioner, in consultation with the e-Health Advisory Committee, shall  
93.31 work to ensure coordination between state, regional, and national efforts to support and  
93.32 accelerate efforts to effectively use health information technology to improve the quality

94.1 and coordination of health care and the continuity of patient care among health care providers,  
 94.2 to reduce medical errors, to improve population health, to reduce health disparities, and to  
 94.3 reduce chronic disease. The commissioner's coordination efforts shall include but not be  
 94.4 limited to:

94.5 ~~(1) assisting in the development and support of health information technology regional~~  
 94.6 ~~extension centers established under section 3012(c) of the HITECH Act to provide technical~~  
 94.7 ~~assistance and disseminate best practices;~~

94.8 ~~(2) providing supplemental information to the best practices gathered by regional centers~~  
 94.9 ~~to ensure that the information is relayed in a meaningful way to the Minnesota health care~~  
 94.10 ~~community;~~

94.11 ~~(3)~~ (1) providing financial and technical support to Minnesota health care providers to  
 94.12 encourage implementation of admission, discharge and transfer alerts, and care summary  
 94.13 document exchange transactions and to evaluate the impact of health information technology  
 94.14 on cost and quality of care. Communications about available financial and technical support  
 94.15 shall include clear information about the interoperable health record requirements in  
 94.16 subdivision 1, including a separate statement in bold-face type clarifying the exceptions to  
 94.17 those requirements;

94.18 ~~(4)~~ (2) providing educational resources and technical assistance to health care providers  
 94.19 and patients related to state and national privacy, security, and consent laws governing  
 94.20 clinical health information, including the requirements in sections 144.291 to 144.298. In  
 94.21 carrying out these activities, the commissioner's technical assistance does not constitute  
 94.22 legal advice;

94.23 ~~(5)~~ (3) assessing Minnesota's legal, financial, and regulatory framework for health  
 94.24 information exchange, including the requirements in sections 144.291 to 144.298, and  
 94.25 making recommendations for modifications that would strengthen the ability of Minnesota  
 94.26 health care providers to securely exchange data in compliance with patient preferences and  
 94.27 in a way that is efficient and financially sustainable; and

94.28 ~~(6)~~ (4) seeking public input on both patient impact and costs associated with requirements  
 94.29 related to patient consent for release of health records for the purposes of treatment, payment,  
 94.30 and health care operations, as required in section 144.293, subdivision 2. The commissioner  
 94.31 shall provide a report to the legislature on the findings of this public input process no later  
 94.32 than February 1, 2017.

94.33 (c) The commissioner, in consultation with the e-Health Advisory Committee, shall  
 94.34 monitor national activity related to health information technology and shall coordinate

95.1 statewide input on policy development. The commissioner shall coordinate statewide  
 95.2 responses to proposed federal health information technology regulations in order to ensure  
 95.3 that the needs of the Minnesota health care community are adequately and efficiently  
 95.4 addressed in the proposed regulations. The commissioner's responses may include, but are  
 95.5 not limited to:

95.6 (1) reviewing and evaluating any standard, implementation specification, or certification  
 95.7 criteria proposed by the national HIT standards ~~committee~~ committees;

95.8 (2) reviewing and evaluating policy proposed by ~~the~~ national HIT policy ~~committee~~  
 95.9 committees relating to the implementation of a nationwide health information technology  
 95.10 infrastructure; and

95.11 (3) ~~monitoring and responding to activity related to the development of quality measures~~  
 95.12 ~~and other measures as required by section 4101 of the HITECH Act. Any response related~~  
 95.13 ~~to quality measures shall consider and address the quality efforts required under chapter~~  
 95.14 ~~62U; and~~

95.15 (4) ~~monitoring and responding to national activity related to privacy, security, and data~~  
 95.16 ~~stewardship of electronic health information and individually identifiable health information.~~

95.17 (d) To the extent that the state is either required or allowed to apply, or designate an  
 95.18 entity to apply for or carry out activities and programs ~~under section 3013 of the HITECH~~  
 95.19 ~~Act~~, the commissioner of health, in consultation with the e-Health Advisory Committee  
 95.20 and the commissioner of human services, shall be the lead applicant or sole designating  
 95.21 authority. The commissioner shall make such designations consistent with the goals and  
 95.22 objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

95.23 (e) The commissioner of human services shall apply for funding necessary to administer  
 95.24 the incentive payments to providers authorized under title IV of the American Recovery  
 95.25 and Reinvestment Act.

95.26 (f) ~~The commissioner shall include in the report to the legislature information on the~~  
 95.27 ~~activities of this subdivision and provide recommendations on any relevant policy changes~~  
 95.28 ~~that should be considered in Minnesota.~~

95.29 Sec. 5. Minnesota Statutes 2020, section 62J.498, is amended to read:

95.30 **62J.498 HEALTH INFORMATION EXCHANGE.**

95.31 Subdivision 1. **Definitions.** (a) The following definitions apply to sections 62J.498 to  
 95.32 62J.4982:

96.1 (b) "Clinical data repository" means a real time database that consolidates data from a  
 96.2 variety of clinical sources to present a unified view of a single patient and is used by a  
 96.3 ~~state-certified~~ health information exchange service provider to enable health information  
 96.4 exchange among health care providers that are not related health care entities as defined in  
 96.5 section 144.291, subdivision 2, paragraph (k). This does not include clinical data that are  
 96.6 submitted to the commissioner for public health purposes required or permitted by law,  
 96.7 including any rules adopted by the commissioner.

96.8 (c) "Clinical transaction" means any meaningful use transaction or other health  
 96.9 information exchange transaction that is not covered by section 62J.536.

96.10 (d) "Commissioner" means the commissioner of health.

96.11 (e) "Health care provider" or "provider" means a health care provider or provider as  
 96.12 defined in section 62J.03, subdivision 8.

96.13 (f) "Health data intermediary" means an entity that provides the technical capabilities  
 96.14 or related products and services to enable health information exchange among health care  
 96.15 providers that are not related health care entities as defined in section 144.291, subdivision  
 96.16 2, paragraph (k). This includes but is not limited to health information service providers  
 96.17 (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries  
 96.18 as defined in section 62J.495.

96.19 (g) "Health information exchange" means the electronic transmission of health-related  
 96.20 information between organizations according to nationally recognized standards.

96.21 (h) "Health information exchange service provider" means a health data intermediary  
 96.22 or health information organization.

96.23 (i) "Health information organization" means an organization that oversees, governs, and  
 96.24 facilitates health information exchange among health care providers that are not related  
 96.25 health care entities as defined in section 144.291, subdivision 2, paragraph (k), to improve  
 96.26 coordination of patient care and the efficiency of health care delivery.

96.27 ~~(j) "HITECH Act" means the Health Information Technology for Economic and Clinical~~  
 96.28 ~~Health Act as defined in section 62J.495.~~

96.29 ~~(k)~~ (j) "Major participating entity" means:

96.30 (1) a participating entity that receives compensation for services that is greater than 30  
 96.31 percent of the health information organization's gross annual revenues from the health  
 96.32 information exchange service provider;



97.1 (2) a participating entity providing administrative, financial, or management services to  
 97.2 the health information organization, if the total payment for all services provided by the  
 97.3 participating entity exceeds three percent of the gross revenue of the health information  
 97.4 organization; and

97.5 (3) a participating entity that nominates or appoints 30 percent or more of the board of  
 97.6 directors or equivalent governing body of the health information organization.

97.7 ~~(h)~~ (k) "Master patient index" means an electronic database that holds unique identifiers  
 97.8 of patients registered at a care facility and is used by a ~~state-certified~~ health information  
 97.9 exchange service provider to enable health information exchange among health care providers  
 97.10 that are not related health care entities as defined in section 144.291, subdivision 2, paragraph  
 97.11 (k). This does not include data that are submitted to the commissioner for public health  
 97.12 purposes required or permitted by law, including any rules adopted by the commissioner.

97.13 ~~(m) "Meaningful use" means use of certified electronic health record technology to~~  
 97.14 ~~improve quality, safety, and efficiency and reduce health disparities; engage patients and~~  
 97.15 ~~families; improve care coordination and population and public health; and maintain privacy~~  
 97.16 ~~and security of patient health information as established by the Centers for Medicare and~~  
 97.17 ~~Medicaid Services and the Minnesota Department of Human Services pursuant to sections~~  
 97.18 ~~4101, 4102, and 4201 of the HITECH Act.~~

97.19 ~~(n) "Meaningful use transaction" means an electronic transaction that a health care~~  
 97.20 ~~provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare~~  
 97.21 ~~penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

97.22 ~~(o)~~ (l) "Participating entity" means any of the following persons, health care providers,  
 97.23 companies, or other organizations with which a health information organization ~~or health~~  
 97.24 ~~data intermediary~~ has contracts or other agreements for the provision of health information  
 97.25 exchange services:

97.26 (1) a health care facility licensed under sections 144.50 to 144.56, a nursing home  
 97.27 licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise  
 97.28 licensed under the laws of this state or registered with the commissioner;

97.29 (2) a health care provider, and any other health care professional otherwise licensed  
 97.30 under the laws of this state or registered with the commissioner;

97.31 (3) a group, professional corporation, or other organization that provides the services of  
 97.32 individuals or entities identified in clause (2), including but not limited to a medical clinic,

98.1 a medical group, a home health care agency, an urgent care center, and an emergent care  
98.2 center;

98.3 (4) a health plan as defined in section 62A.011, subdivision 3; and

98.4 (5) a state agency as defined in section 13.02, subdivision 17.

98.5 ~~(p)~~ (m) "Reciprocal agreement" means an arrangement in which two or more health  
98.6 information exchange service providers agree to share in-kind services and resources to  
98.7 allow for the pass-through of clinical transactions.

98.8 ~~(q) "State-certified health data intermediary" means a health data intermediary that has~~  
98.9 ~~been issued a certificate of authority to operate in Minnesota.~~

98.10 ~~(r)~~ (n) "State-certified health information organization" means a health information  
98.11 organization that has been issued a certificate of authority to operate in Minnesota.

98.12 Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect  
98.13 the public interest on matters pertaining to health information exchange. The commissioner  
98.14 shall:

98.15 (1) review and act on applications from ~~health data intermediaries and~~ health information  
98.16 organizations for certificates of authority to operate in Minnesota;

98.17 (2) require information to be provided as needed from health information exchange  
98.18 service providers in order to meet requirements established under sections 62J.498 to  
98.19 62J.4982;

98.20 ~~(2)~~ (3) provide ongoing monitoring to ensure compliance with criteria established under  
98.21 sections 62J.498 to 62J.4982;

98.22 ~~(3)~~ (4) respond to public complaints related to health information exchange services;

98.23 ~~(4)~~ (5) take enforcement actions as necessary, including the imposition of fines,  
98.24 suspension, or revocation of certificates of authority as outlined in section 62J.4982;

98.25 ~~(5)~~ (6) provide a biennial report on the status of health information exchange services  
98.26 that includes but is not limited to:

98.27 (i) recommendations on actions necessary to ensure that health information exchange  
98.28 services are adequate to meet the needs of Minnesota citizens and providers statewide;

98.29 (ii) recommendations on enforcement actions to ensure that health information exchange  
98.30 service providers act in the public interest without causing disruption in health information  
98.31 exchange services;

99.1 (iii) recommendations on updates to criteria for obtaining certificates of authority under  
99.2 this section; and

99.3 (iv) recommendations on standard operating procedures for health information exchange,  
99.4 including but not limited to the management of consumer preferences; and

99.5 ~~(6)~~ (7) other duties necessary to protect the public interest.

99.6 (b) As part of the application review process for certification under paragraph (a), prior  
99.7 to issuing a certificate of authority, the commissioner shall:

99.8 (1) make all portions of the application classified as public data available to the public  
99.9 for at least ten days while an application is under consideration. At the request of the  
99.10 commissioner, the applicant shall participate in a public hearing by presenting an overview  
99.11 of their application and responding to questions from interested parties; and

99.12 (2) consult with hospitals, physicians, and other providers prior to issuing a certificate  
99.13 of authority.

99.14 (c) When the commissioner is actively considering a suspension or revocation of a  
99.15 certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data  
99.16 that are collected, created, or maintained related to the suspension or revocation are classified  
99.17 as confidential data on individuals and as protected nonpublic data in the case of data not  
99.18 on individuals.

99.19 (d) The commissioner may disclose data classified as protected nonpublic or confidential  
99.20 under paragraph (c) if disclosing the data will protect the health or safety of patients.

99.21 (e) After the commissioner makes a final determination regarding a suspension or  
99.22 revocation of a certificate of authority, all minutes, orders for hearing, findings of fact,  
99.23 conclusions of law, and the specification of the final disciplinary action, are classified as  
99.24 public data.

99.25 Sec. 6. Minnesota Statutes 2020, section 62J.4981, is amended to read:

99.26 **62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH**  
99.27 **INFORMATION EXCHANGE SERVICES.**

99.28 Subdivision 1. **Authority to require organizations to apply.** The commissioner shall  
99.29 require ~~a health data intermediary or~~ a health information organization to apply for a  
99.30 certificate of authority under this section. An applicant may continue to operate until the  
99.31 commissioner acts on the application. If the application is denied, the applicant is considered

100.1 a health information exchange service provider whose certificate of authority has been  
100.2 revoked under section 62J.4982, subdivision 2, paragraph (d).

100.3 ~~Subd. 2. Certificate of authority for health data intermediaries. (a) A health data~~  
100.4 ~~intermediary must be certified by the state and comply with requirements established in this~~  
100.5 ~~section.~~

100.6 ~~(b) Notwithstanding any law to the contrary, any corporation organized to do so may~~  
100.7 ~~apply to the commissioner for a certificate of authority to establish and operate as a health~~  
100.8 ~~data intermediary in compliance with this section. No person shall establish or operate a~~  
100.9 ~~health data intermediary in this state, nor sell or offer to sell, or solicit offers to purchase~~  
100.10 ~~or receive advance or periodic consideration in conjunction with a health data intermediary~~  
100.11 ~~contract unless the organization has a certificate of authority or has an application under~~  
100.12 ~~active consideration under this section.~~

100.13 ~~(c) In issuing the certificate of authority, the commissioner shall determine whether the~~  
100.14 ~~applicant for the certificate of authority has demonstrated that the applicant meets the~~  
100.15 ~~following minimum criteria:~~

100.16 ~~(1) hold reciprocal agreements with at least one state-certified health information~~  
100.17 ~~organization to access patient data, and for the transmission and receipt of clinical~~  
100.18 ~~transactions. Reciprocal agreements must meet the requirements established in subdivision~~  
100.19 ~~5; and~~

100.20 ~~(2) participate in statewide shared health information exchange services as defined by~~  
100.21 ~~the commissioner to support interoperability between state-certified health information~~  
100.22 ~~organizations and state-certified health data intermediaries.~~

100.23 **Subd. 3. Certificate of authority for health information organizations.** (a) A health  
100.24 information organization must obtain a certificate of authority from the commissioner and  
100.25 demonstrate compliance with the criteria in paragraph (c).

100.26 (b) Notwithstanding any law to the contrary, an organization may apply for a certificate  
100.27 of authority to establish and operate a health information organization under this section.  
100.28 No person shall establish or operate a health information organization in this state, nor sell  
100.29 or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in  
100.30 conjunction with a health information organization or health information contract unless  
100.31 the organization has a certificate of authority under this section.

101.1 (c) In issuing the certificate of authority, the commissioner shall determine whether the  
101.2 applicant for the certificate of authority has demonstrated that the applicant meets the  
101.3 following minimum criteria:

101.4 (1) the entity is a legally established organization;

101.5 (2) appropriate insurance, including liability insurance, for the operation of the health  
101.6 information organization is in place and sufficient to protect the interest of the public and  
101.7 participating entities;

101.8 (3) strategic and operational plans address governance, technical infrastructure, legal  
101.9 and policy issues, finance, and business operations in regard to how the organization will  
101.10 expand to support providers in achieving health information exchange goals over time;

101.11 (4) the entity addresses the parameters to be used with participating entities and other  
101.12 health information exchange service providers for clinical transactions, compliance with  
101.13 Minnesota law, and interstate health information exchange trust agreements;

101.14 (5) the entity's board of directors or equivalent governing body is composed of members  
101.15 that broadly represent the health information organization's participating entities and  
101.16 consumers;

101.17 (6) the entity maintains a professional staff responsible to the board of directors or  
101.18 equivalent governing body with the capacity to ensure accountability to the organization's  
101.19 mission;

101.20 (7) the organization is compliant with national certification and accreditation programs  
101.21 designated by the commissioner;

101.22 (8) the entity maintains the capability to query for patient information based on national  
101.23 standards. The query capability may utilize a master patient index, clinical data repository,  
101.24 or record locator service as defined in section 144.291, subdivision 2, paragraph (j). The  
101.25 entity must be compliant with the requirements of section 144.293, subdivision 8, when  
101.26 conducting clinical transactions;

101.27 (9) the organization demonstrates interoperability with all other state-certified health  
101.28 information organizations using nationally recognized standards;

101.29 (10) the organization demonstrates compliance with all privacy and security requirements  
101.30 required by state and federal law; and

102.1 (11) the organization uses financial policies and procedures consistent with generally  
 102.2 accepted accounting principles and has an independent audit of the organization's financials  
 102.3 on an annual basis.

102.4 (d) Health information organizations that have obtained a certificate of authority must:

102.5 (1) meet the requirements established for connecting to the National eHealth Exchange;

102.6 (2) annually submit strategic and operational plans for review by the commissioner that  
 102.7 address:

102.8 (i) progress in achieving objectives included in previously submitted strategic and  
 102.9 operational plans across the following domains: business and technical operations, technical  
 102.10 infrastructure, legal and policy issues, finance, and organizational governance;

102.11 (ii) plans for ensuring the necessary capacity to support clinical transactions;

102.12 (iii) approach for attaining financial sustainability, including public and private financing  
 102.13 strategies, and rate structures;

102.14 (iv) rates of adoption, utilization, and transaction volume, and mechanisms to support  
 102.15 health information exchange; and

102.16 (v) an explanation of methods employed to address the needs of community clinics,  
 102.17 critical access hospitals, and free clinics in accessing health information exchange services;

102.18 (3) enter into reciprocal agreements with all other state-certified health information  
 102.19 organizations ~~and state-certified health data intermediaries~~ to enable access to patient data,  
 102.20 and for the transmission and receipt of clinical transactions. Reciprocal agreements must  
 102.21 meet the requirements in subdivision 5;

102.22 (4) participate in statewide shared health information exchange services as defined by  
 102.23 the commissioner to support interoperability ~~between state-certified health information~~  
 102.24 ~~organizations and state-certified health data intermediaries~~; and

102.25 (5) comply with additional requirements for the certification or recertification of health  
 102.26 information organizations that may be established by the commissioner.

102.27 **Subd. 4. Application for certificate of authority for health information exchange**  
 102.28 **service providers organizations.** (a) Each application for a certificate of authority shall  
 102.29 be in a form prescribed by the commissioner and verified by an officer or authorized  
 102.30 representative of the applicant. Each application shall include the following in addition to  
 102.31 information described in the criteria in ~~subdivisions 2 and~~ subdivision 3:

103.1 (1) ~~for health information organizations only~~, a copy of the basic organizational document,  
103.2 if any, of the applicant and of each major participating entity, such as the articles of  
103.3 incorporation, or other applicable documents, and all amendments to it;

103.4 (2) ~~for health information organizations only~~, a list of the names, addresses, and official  
103.5 positions of the following:

103.6 (i) all members of the board of directors or equivalent governing body, and the principal  
103.7 officers and, if applicable, shareholders of the applicant organization; and

103.8 (ii) all members of the board of directors or equivalent governing body, and the principal  
103.9 officers of each major participating entity and, if applicable, each shareholder beneficially  
103.10 owning more than ten percent of any voting stock of the major participating entity;

103.11 (3) ~~for health information organizations only~~, the name and address of each participating  
103.12 entity and the agreed-upon duration of each contract or agreement if applicable;

103.13 (4) a copy of each standard agreement or contract intended to bind the participating  
103.14 entities and the health information ~~exchange service provider~~ organization. Contractual  
103.15 provisions shall be consistent with the purposes of this section, in regard to the services to  
103.16 be performed under the standard agreement or contract, the manner in which payment for  
103.17 services is determined, the nature and extent of responsibilities to be retained by the health  
103.18 information organization, and contractual termination provisions;

103.19 (5) a statement generally describing the health information ~~exchange service provider~~  
103.20 organization, its health information exchange contracts, facilities, and personnel, including  
103.21 a statement describing the manner in which the applicant proposes to provide participants  
103.22 with comprehensive health information exchange services;

103.23 (6) a statement reasonably describing the geographic area or areas to be served and the  
103.24 type or types of participants to be served;

103.25 (7) a description of the complaint procedures to be used as required under this section;

103.26 (8) a description of the mechanism by which participating entities will have an opportunity  
103.27 to participate in matters of policy and operation;

103.28 (9) a copy of any pertinent agreements between the health information organization and  
103.29 insurers, including liability insurers, demonstrating coverage is in place;

103.30 (10) a copy of the conflict of interest policy that applies to all members of the board of  
103.31 directors or equivalent governing body and the principal officers of the health information  
103.32 organization; and

104.1 (11) other information as the commissioner may reasonably require to be provided.

104.2 (b) Within 45 days after the receipt of the application for a certificate of authority, the  
104.3 commissioner shall determine whether or not the application submitted meets the  
104.4 requirements for completion in paragraph (a), and notify the applicant of any further  
104.5 information required for the application to be processed.

104.6 (c) Within 90 days after the receipt of a complete application for a certificate of authority,  
104.7 the commissioner shall issue a certificate of authority to the applicant if the commissioner  
104.8 determines that the applicant meets the minimum criteria requirements of subdivision 2 ~~for~~  
104.9 ~~health data intermediaries or subdivision 3 for health information organizations~~. If the  
104.10 commissioner determines that the applicant is not qualified, the commissioner shall notify  
104.11 the applicant and specify the reasons for disqualification.

104.12 (d) Upon being granted a certificate of authority to operate as a state-certified health  
104.13 information organization ~~or state-certified health data intermediary~~, the organization must  
104.14 operate in compliance with the provisions of this section. Noncompliance may result in the  
104.15 imposition of a fine or the suspension or revocation of the certificate of authority according  
104.16 to section 62J.4982.

104.17 Subd. 5. **Reciprocal agreements between health information exchange entities**  
104.18 **organizations**. (a) Reciprocal agreements between two health information organizations  
104.19 ~~or between a health information organization and a health data intermediary~~ must include  
104.20 a fair and equitable model for charges between the entities that:

104.21 (1) does not impede the secure transmission of clinical transactions;

104.22 (2) does not charge a fee for the exchange of ~~meaningful use~~ transactions transmitted  
104.23 according to nationally recognized standards where no additional value-added service is  
104.24 rendered to the sending or receiving health information organization ~~or health data~~  
104.25 ~~intermediary~~ either directly or on behalf of the client;

104.26 (3) is consistent with fair market value and proportionately reflects the value-added  
104.27 services accessed as a result of the agreement; and

104.28 (4) prevents health care stakeholders from being charged multiple times for the same  
104.29 service.

104.30 (b) Reciprocal agreements must include comparable quality of service standards that  
104.31 ensure equitable levels of services.

104.32 (c) Reciprocal agreements are subject to review and approval by the commissioner.



105.1 (d) Nothing in this section precludes a state-certified health information organization or  
 105.2 ~~state-certified health data intermediary~~ from entering into contractual agreements for the  
 105.3 provision of value-added services ~~beyond meaningful use transactions.~~

105.4 Sec. 7. Minnesota Statutes 2020, section 62J.4982, is amended to read:

105.5 **62J.4982 ENFORCEMENT AUTHORITY; COMPLIANCE.**

105.6 Subdivision 1. **Penalties and enforcement.** (a) The commissioner may, for any violation  
 105.7 of statute or rule applicable to a health information ~~exchange service provider~~ organization,  
 105.8 levy an administrative penalty in an amount up to \$25,000 for each violation. In determining  
 105.9 the level of an administrative penalty, the commissioner shall consider the following factors:

105.10 (1) the number of participating entities affected by the violation;

105.11 (2) the effect of the violation on participating entities' access to health information  
 105.12 exchange services;

105.13 (3) if only one participating entity is affected, the effect of the violation on the patients  
 105.14 of that entity;

105.15 (4) whether the violation is an isolated incident or part of a pattern of violations;

105.16 (5) the economic benefits derived by the health information organization or a ~~health data~~  
 105.17 ~~intermediary~~ by virtue of the violation;

105.18 (6) whether the violation hindered or facilitated an individual's ability to obtain health  
 105.19 care;

105.20 (7) whether the violation was intentional;

105.21 (8) whether the violation was beyond the direct control of the health information ~~exchange~~  
 105.22 ~~service provider~~ organization;

105.23 (9) any history of prior compliance with the provisions of this section, including  
 105.24 violations;

105.25 (10) whether and to what extent the health information ~~exchange service provider~~  
 105.26 organization attempted to correct previous violations;

105.27 (11) how the health information ~~exchange service provider~~ organization responded to  
 105.28 technical assistance from the commissioner provided in the context of a compliance effort;  
 105.29 and

105.30 (12) the financial condition of the health information ~~exchange service provider~~  
 105.31 organization including, but not limited to, whether the health information ~~exchange service~~

106.1 ~~provider~~ organization had financial difficulties that affected its ability to comply or whether  
106.2 the imposition of an administrative monetary penalty would jeopardize the ability of the  
106.3 health information ~~exchange service provider~~ organization to continue to deliver health  
106.4 information exchange services.

106.5 The commissioner shall give reasonable notice in writing to the health information  
106.6 ~~exchange service provider~~ organization of the intent to levy the penalty and the reasons for  
106.7 it. A health information ~~exchange service provider~~ organization may have 15 days within  
106.8 which to contest whether the facts found constitute a violation of sections 62J.4981 and  
106.9 62J.4982, according to the contested case and judicial review provisions of sections 14.57  
106.10 to 14.69.

106.11 (b) If the commissioner has reason to believe that a violation of section 62J.4981 or  
106.12 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved  
106.13 before commencing action under subdivision 2. The commissioner may notify the health  
106.14 information ~~exchange service provider~~ organization and the representatives, or other persons  
106.15 who appear to be involved in the suspected violation, to arrange a voluntary conference  
106.16 with the alleged violators or their authorized representatives. The purpose of the conference  
106.17 is to attempt to learn the facts about the suspected violation and, if it appears that a violation  
106.18 has occurred or is threatened, to find a way to correct or prevent it. The conference is not  
106.19 governed by any formal procedural requirements, and may be conducted as the commissioner  
106.20 considers appropriate.

106.21 (c) The commissioner may issue an order directing a health information ~~exchange service~~  
106.22 ~~provider~~ organization or a representative of a health information ~~exchange service provider~~  
106.23 organization to cease and desist from engaging in any act or practice in violation of sections  
106.24 62J.4981 and 62J.4982.

106.25 (d) Within 20 days after service of the order to cease and desist, a health information  
106.26 ~~exchange service provider~~ organization may contest whether the facts found constitute a  
106.27 violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial  
106.28 review provisions of sections 14.57 to 14.69.

106.29 (e) In the event of noncompliance with a cease and desist order issued under this  
106.30 subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other  
106.31 appropriate relief in Ramsey County District Court.

106.32 Subd. 2. **Suspension or revocation of certificates of authority.** (a) The commissioner  
106.33 may suspend or revoke a certificate of authority issued to a ~~health data intermediary or~~  
106.34 health information organization under section 62J.4981 if the commissioner finds that:

107.1 (1) the health information ~~exchange service provider~~ organization is operating  
107.2 significantly in contravention of its basic organizational document, or in a manner contrary  
107.3 to that described in and reasonably inferred from any other information submitted under  
107.4 section 62J.4981, unless amendments to the submissions have been filed with and approved  
107.5 by the commissioner;

107.6 (2) the health information ~~exchange service provider~~ organization is unable to fulfill its  
107.7 obligations to furnish comprehensive health information exchange services as required  
107.8 under its health information exchange contract;

107.9 (3) the health information ~~exchange service provider~~ organization is no longer financially  
107.10 solvent or may not reasonably be expected to meet its obligations to participating entities;

107.11 (4) the health information ~~exchange service provider~~ organization has failed to implement  
107.12 the complaint system in a manner designed to reasonably resolve valid complaints;

107.13 (5) the health information ~~exchange service provider~~ organization, or any person acting  
107.14 with its sanction, has advertised or merchandised its services in an untrue, misleading,  
107.15 deceptive, or unfair manner;

107.16 (6) the continued operation of the health information ~~exchange service provider~~  
107.17 organization would be hazardous to its participating entities or the patients served by the  
107.18 participating entities; or

107.19 (7) the health information ~~exchange service provider~~ organization has otherwise failed  
107.20 to substantially comply with section 62J.4981 or with any other statute or administrative  
107.21 rule applicable to health information exchange service providers, or has submitted false  
107.22 information in any report required under sections 62J.498 to 62J.4982.

107.23 (b) A certificate of authority shall be suspended or revoked only after meeting the  
107.24 requirements of subdivision 3.

107.25 (c) If the certificate of authority of a health information ~~exchange service provider~~  
107.26 organization is suspended, the health information ~~exchange service provider~~ organization  
107.27 shall not, during the period of suspension, enroll any additional participating entities, and  
107.28 shall not engage in any advertising or solicitation.

107.29 (d) If the certificate of authority of a health information ~~exchange service provider~~  
107.30 organization is revoked, the organization shall proceed, immediately following the effective  
107.31 date of the order of revocation, to wind up its affairs, and shall conduct no further business  
107.32 except as necessary to the orderly conclusion of the affairs of the organization. The  
107.33 organization shall engage in no further advertising or solicitation. The commissioner may,

108.1 by written order, permit further operation of the organization as the commissioner finds to  
108.2 be in the best interest of participating entities, to the end that participating entities will be  
108.3 given the greatest practical opportunity to access continuing health information exchange  
108.4 services.

108.5 Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a) When  
108.6 the commissioner has cause to believe that grounds for the denial, suspension, or revocation  
108.7 of a certificate of authority exist, the commissioner shall notify the health information  
108.8 ~~exchange service provider~~ organization in writing stating the grounds for denial, suspension,  
108.9 or revocation and setting a time within 20 days for a hearing on the matter.

108.10 (b) After a hearing before the commissioner at which the health information ~~exchange~~  
108.11 ~~service provider~~ organization may respond to the grounds for denial, suspension, or  
108.12 revocation, or upon the failure of the health information exchange service provider to appear  
108.13 at the hearing, the commissioner shall take action as deemed necessary and shall issue  
108.14 written findings and mail them to the health information ~~exchange service provider~~  
108.15 organization.

108.16 (c) If suspension, revocation, or administrative penalty is proposed according to this  
108.17 section, the commissioner must deliver, or send by certified mail with return receipt  
108.18 requested, to the health information ~~exchange service provider~~ organization written notice  
108.19 of the commissioner's intent to impose a penalty. This notice of proposed determination  
108.20 must include:

108.21 (1) a reference to the statutory basis for the penalty;

108.22 (2) a description of the findings of fact regarding the violations with respect to which  
108.23 the penalty is proposed;

108.24 (3) the nature and amount of the proposed penalty;

108.25 (4) any circumstances described in subdivision 1, paragraph (a), that were considered  
108.26 in determining the amount of the proposed penalty;

108.27 (5) instructions for responding to the notice, including a statement of the health  
108.28 information ~~exchange service provider's~~ organization's right to a contested case proceeding  
108.29 and a statement that failure to request a contested case proceeding within 30 calendar days  
108.30 permits the imposition of the proposed penalty; and

108.31 (6) the address to which the contested case proceeding request must be sent.

108.32 Subd. 4. **Coordination.** The commissioner shall, to the extent possible, seek the advice  
108.33 of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the

109.1 certification and recertification of health information ~~exchange service providers~~  
 109.2 organizations when implementing sections 62J.498 to 62J.4982.

109.3 Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every  
 109.4 health information ~~exchange service provider~~ organization subject to sections 62J.4981 and  
 109.5 62J.4982 as follows:

109.6 (1) filing an application for certificate of authority to operate as a health information  
 109.7 organization, \$7,000; and

109.8 (2) ~~filing an application for certificate of authority to operate as a health data intermediary,~~  
 109.9 ~~\$7,000;~~

109.10 (3) ~~annual health information organization certificate fee, \$7,000; and.~~

109.11 (4) ~~annual health data intermediary certificate fee, \$7,000.~~

109.12 (b) Fees collected under this section shall be deposited in the state treasury and credited  
 109.13 to the state government special revenue fund.

109.14 (c) Administrative monetary penalties imposed under this subdivision shall be credited  
 109.15 to an account in the special revenue fund and are appropriated to the commissioner for the  
 109.16 purposes of sections 62J.498 to 62J.4982.

109.17 Sec. 8. Minnesota Statutes 2020, section 144.1205, subdivision 2, is amended to read:

109.18 Subd. 2. **Initial and annual fee.** (a) A licensee must pay an initial fee that is equivalent  
 109.19 to the annual fee upon issuance of the initial license.

109.20 (b) A licensee must pay an annual fee at least 60 days before the anniversary date of the  
 109.21 issuance of the license. The annual fee is as follows:

| 109.22 |   | <u>ANNUAL</u>      |
|--------|---|--------------------|
| 109.23 | TYPE  | <u>LICENSE FEE</u> |
| 109.24 |   | <u>\$19,920</u>    |
| 109.25 | Academic broad scope - type A, B, or C                              | <u>\$25,896</u>    |
| 109.26 | <del>Academic broad scope - type B</del>                            | <del>19,920</del>  |
| 109.27 | <del>Academic broad scope - type C</del>                            | <del>19,920</del>  |
| 109.28 | <u>Academic broad scope - type A, B, or C (4-8 locations)</u>       | <u>\$31,075</u>    |
| 109.29 | <u>Academic broad scope - type A, B, or C (9 or more locations)</u> | <u>\$36,254</u>    |
| 109.30 |   | <del>19,920</del>  |
| 109.31 | Medical broad scope - type A  | <u>\$25,896</u>    |
| 109.32 | <u>Medical broad scope- type A (4-8 locations)</u>                  | <u>\$31,075</u>    |
| 109.33 | <u>Medical broad scope- type A (9 or more locations)</u>            | <u>\$36,254</u>    |

|        |  |                                 |
|--------|--|---------------------------------|
| 110.1  | <del>Medical institution – diagnostic and therapeutic</del>              | 3,680                           |
| 110.2  | <u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>  |                                 |
| 110.3  | <u>medicine, eye applicators, high dose rate afterloaders, and</u>       |                                 |
| 110.4  | <u>medical therapy emerging technologies</u>                             | <u>\$4,784</u>                  |
| 110.5  | <u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>  |                                 |
| 110.6  | <u>medicine, eye applicators, high dose rate afterloaders, and</u>       |                                 |
| 110.7  | <u>medical therapy emerging technologies (4-8 locations)</u>             | <u>\$5,740</u>                  |
| 110.8  | <u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>  |                                 |
| 110.9  | <u>medicine, eye applicators, high dose rate afterloaders, and</u>       |                                 |
| 110.10 | <u>medical therapy emerging technologies (9 or more locations)</u>       | <u>\$6,697</u>                  |
| 110.11 | <del>Medical institution – diagnostic (no written directives)</del>      | 3,680                           |
| 110.12 | <del>Medical private practice – diagnostic and therapeutic</del>         | 3,680                           |
| 110.13 | <del>Medical private practice – diagnostic (no written directives)</del> | 3,680                           |
| 110.14 | <del>Eye applicators</del>   | 3,680                           |
| 110.15 | <del>Nuclear medical vans</del>  | 3,680                           |
| 110.16 | <del>High dose rate afterloader</del>                                    | 3,680                           |
| 110.17 | <del>Mobile high dose rate afterloader</del>                             | 3,680                           |
| 110.18 | <del>Medical therapy – other emerging technology</del>                   | 3,680                           |
| 110.19 |  | <del>8,960</del>                |
| 110.20 | Teletherapy  | <u>\$11,648</u>                 |
| 110.21 |  | 8,960                           |
| 110.22 | Gamma knife  | <u>\$11,648</u>                 |
| 110.23 | Veterinary medicine  | <del>2,000</del> <u>\$2,600</u> |
| 110.24 | In vitro testing lab   | <del>2,000</del> <u>\$2,600</u> |
| 110.25 |  | 8,800                           |
| 110.26 | Nuclear pharmacy   | <u>\$11,440</u>                 |
| 110.27 | <u>Nuclear pharmacy (5 or more locations)</u>                            | <u>\$13,728</u>                 |
| 110.28 | Radiopharmaceutical distribution (10 CFR 32.72)                          | <del>3,840</del> <u>\$4,992</u> |
| 110.29 | Radiopharmaceutical processing and distribution (10 CFR                  | 8,800                           |
| 110.30 | 32.72)   | <u>\$11,440</u>                 |
| 110.31 | <u>Radiopharmaceutical processing and distribution (10 CFR</u>           | <u>\$13,728</u>                 |
| 110.32 | <u>32.72) (5 or more locations)</u>                                      |                                 |
| 110.33 | Medical sealed sources - distribution (10 CFR 32.74)                     | <del>3,840</del> <u>\$4,992</u> |
| 110.34 | Medical sealed sources - processing and distribution (10 CFR             | 8,800                           |
| 110.35 | 32.74)   | <u>\$11,440</u>                 |
| 110.36 | Medical sealed sources - processing and distribution (10 CFR             | <u>\$13,728</u>                 |
| 110.37 | <u>32.74) (5 or more locations)</u>                                      |                                 |
| 110.38 | Well logging - sealed sources  | <del>3,760</del> <u>\$4,888</u> |
| 110.39 | Measuring systems - (fixed gauge, portable gauge, gas                    |                                 |
| 110.40 | <u>chromatograph, other)</u>   | <del>2,000</del> <u>\$2,600</u> |
| 110.41 | <del>Measuring systems – portable gauge</del>                            | 2,000                           |
| 110.42 | <u>Measuring systems - (fixed gauge, portable gauge, gas</u>             |                                 |
| 110.43 | <u>chromatograph, other) (4-8 locations)</u>                             | <u>\$3,120</u>                  |

|        |  |                  |                 |
|--------|--|------------------|-----------------|
| 111.1  | <u>Measuring systems - (fixed gauge, portable gauge, gas</u>                     |                  |                 |
| 111.2  | <u>chromatograph, other) (9 or more locations)</u>                               |                  | <u>\$3,640</u>  |
| 111.3  | X-ray fluorescent analyzer   | <del>1,520</del> | <u>\$1,976</u>  |
| 111.4  | <del>Measuring systems - gas chromatograph</del>                                 |                  | <u>2,000</u>    |
| 111.5  | <del>Measuring systems - other</del>   |                  | <u>2,000</u>    |
| 111.6  | <del>Broad scope</del> Manufacturing and distribution - type A <u>broad</u>      |                  | <u>19,920</u>   |
| 111.7  | <u>scope</u>   |                  | <u>\$25,896</u> |
| 111.8  | <u>Manufacturing and distribution - type A broad scope (4-8</u>                  |                  |                 |
| 111.9  | <u>locations)</u>  |                  | <u>\$31,075</u> |
| 111.10 | <u>Manufacturing and distribution - type A broad scope (9 or more</u>            |                  |                 |
| 111.11 | <u>locations)</u>  |                  | <u>\$36,254</u> |
| 111.12 | <del>Broad scope</del> Manufacturing and distribution - type B <u>or C broad</u> |                  | <u>17,600</u>   |
| 111.13 | <u>scope</u>   |                  | <u>\$22,880</u> |
| 111.14 | <del>Broad scope</del> Manufacturing and distribution - type <u>C</u>            |                  | <u>17,600</u>   |
| 111.15 | <u>Manufacturing and distribution - type B or C broad scope (4-8</u>             |                  |                 |
| 111.16 | <u>locations)</u>  |                  | <u>\$27,456</u> |
| 111.17 | <u>Manufacturing and distribution - type B or C broad scope (9</u>               |                  |                 |
| 111.18 | <u>or more locations)</u>  |                  | <u>\$32,032</u> |
| 111.19 | Manufacturing and distribution - other   | <del>5,280</del> | <u>\$6,864</u>  |
| 111.20 | <u>Manufacturing and distribution - other (4-8 locations)</u>                    |                  | <u>\$8,236</u>  |
| 111.21 | <u>Manufacturing and distribution - other (9 or more locations)</u>              |                  | <u>\$9,609</u>  |
| 111.22 |  |                  | <u>18,640</u>   |
| 111.23 | Nuclear laundry  |                  | <u>\$24,232</u> |
| 111.24 | Decontamination services   | <del>4,960</del> | <u>\$6,448</u>  |
| 111.25 | Leak test services only  | <del>2,000</del> | <u>\$2,600</u>  |
| 111.26 | Instrument calibration service only, <del>less than 100 curies</del>             | <del>2,000</del> | <u>\$2,600</u>  |
| 111.27 | <del>Instrument calibration service only, 100 curies or more</del>               |                  | <u>2,000</u>    |
| 111.28 | Service, maintenance, installation, source changes, etc.                         | <del>4,960</del> | <u>\$6,448</u>  |
| 111.29 | Waste disposal service, prepackaged only   | <del>6,000</del> | <u>\$7,800</u>  |
| 111.30 |  |                  | <u>8,320</u>    |
| 111.31 | Waste disposal   |                  | <u>\$10,816</u> |
| 111.32 | Distribution - general licensed devices (sealed sources)                         | <del>1,760</del> | <u>\$2,288</u>  |
| 111.33 | Distribution - general licensed material (unsealed sources)                      | <del>1,120</del> | <u>\$1,456</u>  |
| 111.34 |  |                  | <u>9,840</u>    |
| 111.35 | Industrial radiography - fixed <u>or temporary</u> location                      |                  | <u>\$12,792</u> |
| 111.36 | <del>Industrial radiography - temporary job sites</del>                          |                  | <u>9,840</u>    |
| 111.37 | <u>Industrial radiography - fixed or temporary location (5 or more</u>           |                  |                 |
| 111.38 | <u>locations)</u>  |                  | <u>\$16,629</u> |
| 111.39 | Irradiators, self-shielding, <del>less than 10,000 curies</del>                  | <del>2,880</del> | <u>\$3,744</u>  |
| 111.40 | Irradiators, other, less than 10,000 curies                                      | <del>5,360</del> | <u>\$6,968</u>  |
| 111.41 | <del>Irradiators, self-shielding, 10,000 curies or more</del>                    |                  | <u>2,880</u>    |

|        |   |                      |
|--------|---|----------------------|
| 112.1  |   | 9,520                |
| 112.2  | Research and development - type A, B, or C broad scope              | <u>\$12,376</u>      |
| 112.3  | <del>Research and development - type B broad scope</del>            | 9,520                |
| 112.4  | <del>Research and development - type C broad scope</del>            | 9,520                |
| 112.5  | <u>Research and development - type A, B, or C broad scope (4-8</u>  |                      |
| 112.6  | <u>locations)</u>   | <u>\$14,851</u>      |
| 112.7  | <u>Research and development - type A, B, or C broad scope (9 or</u> |                      |
| 112.8  | <u>more locations)</u>  | <u>\$17,326</u>      |
| 112.9  | Research and development - other                                    | 4,480 <u>\$5,824</u> |
| 112.10 | Storage - no operations   | 2,000 <u>\$2,600</u> |
| 112.11 | Source material - shielding   | 584 <u>\$759</u>     |
| 112.12 | Special nuclear material plutonium - neutron source in device       | 3,680 <u>\$4,784</u> |
| 112.13 | Pacemaker by-product and/or special nuclear material - medical      | 3,680 <u>\$4,784</u> |
| 112.14 | (institution)   |                      |
| 112.15 | Pacemaker by-product and/or special nuclear material -              | 5,280 <u>\$6,864</u> |
| 112.16 | manufacturing and distribution                                      |                      |
| 112.17 | Accelerator-produced radioactive material                           | 3,840 <u>\$4,992</u> |
| 112.18 | Nonprofit educational institutions                                  | 300 <u>\$500</u>     |
| 112.19 | <del>General license registration</del>                             | 150                  |

112.20 Sec. 9. Minnesota Statutes 2020, section 144.1205, subdivision 4, is amended to read:

112.21 Subd. 4. **Initial and renewal application fee.** A licensee must pay an initial and a  
 112.22 renewal application fee as follows: according to this subdivision.

| 112.23 | TYPE   | APPLICATION FEE      |
|--------|--|----------------------|
| 112.24 |  | <del>\$5,920</del>   |
| 112.25 | Academic broad scope - type A, B, or C                                   | <u>\$6,808</u>       |
| 112.26 | <del>Academic broad scope - type B</del>                                 | 5,920                |
| 112.27 | <del>Academic broad scope - type C</del>                                 | 5,920                |
| 112.28 | Medical broad scope - type A   | 3,920 <u>\$4,508</u> |
| 112.29 | <u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>  |                      |
| 112.30 | <u>medicine, eye applicators, high dose rate afterloaders, and</u>       |                      |
| 112.31 | <u>medical therapy emerging technologies</u>                             | <u>\$1,748</u>       |
| 112.32 | <del>Medical institution - diagnostic and therapeutic</del>              | 1,520                |
| 112.33 | <del>Medical institution - diagnostic (no written directives)</del>      | 1,520                |
| 112.34 | <del>Medical private practice - diagnostic and therapeutic</del>         | 1,520                |
| 112.35 | <del>Medical private practice - diagnostic (no written directives)</del> | 1,520                |
| 112.36 | <del>Eye applicators</del>   | 1,520                |
| 112.37 | <del>Nuclear medical vans</del>  | 1,520                |
| 112.38 | <del>High dose rate afterloader</del>                                    | 1,520                |
| 112.39 | <del>Mobile high dose rate afterloader</del>                             | 1,520                |



|        |   |       |                   |
|--------|---|-------|-------------------|
| 113.1  | <del>Medical therapy—other emerging technology</del>                          |       | <del>1,520</del>  |
| 113.2  | Teletherapy   | 5,520 | <u>\$6,348</u>    |
| 113.3  | Gamma knife   | 5,520 | <u>\$6,348</u>    |
| 113.4  | Veterinary medicine   | 960   | <u>\$1,104</u>    |
| 113.5  | In vitro testing lab  | 960   | <u>\$1,104</u>    |
| 113.6  | Nuclear pharmacy  | 4,880 | <u>\$5,612</u>    |
| 113.7  | Radiopharmaceutical distribution (10 CFR 32.72)                               | 2,160 | <u>\$2,484</u>    |
| 113.8  | Radiopharmaceutical processing and distribution (10 CFR                       |       |                   |
| 113.9  | 32.72)  | 4,880 | <u>\$5,612</u>    |
| 113.10 | Medical sealed sources - distribution (10 CFR 32.74)                          | 2,160 | <u>\$2,484</u>    |
| 113.11 | Medical sealed sources - processing and distribution (10 CFR                  |       |                   |
| 113.12 | 32.74)  | 4,880 | <u>\$5,612</u>    |
| 113.13 | Well logging - sealed sources   | 1,600 | <u>\$1,840</u>    |
| 113.14 | Measuring systems - (fixed gauge, portable gauge, gas                         |       |                   |
| 113.15 | <u>chromatograph, other)</u>  | 960   | <u>\$1,104</u>    |
| 113.16 | <del>Measuring systems—portable gauge</del>                                   |       | <del>960</del>    |
| 113.17 | X-ray fluorescent analyzer  | 584   | <u>\$671</u>      |
| 113.18 | <del>Measuring systems—gas chromatograph</del>                                |       | <del>960</del>    |
| 113.19 | <del>Measuring systems—other</del>  |       | <del>960</del>    |
| 113.20 | <del>Broad scope</del> Manufacturing and distribution - type A, <u>B, and</u> |       |                   |
| 113.21 | <u>C broad scope</u>  | 5,920 | <u>\$6,854</u>    |
| 113.22 | <del>Broad scope manufacturing and distribution—type B</del>                  |       | <del>5,920</del>  |
| 113.23 | <del>Broad scope manufacturing and distribution—type C</del>                  |       | <del>5,920</del>  |
| 113.24 | Manufacturing and distribution - other  | 2,320 | <u>\$2,668</u>    |
| 113.25 |   |       | <del>10,080</del> |
| 113.26 | Nuclear laundry   |       | <u>\$11,592</u>   |
| 113.27 | Decontamination services  | 2,640 | <u>\$3,036</u>    |
| 113.28 | Leak test services only   | 960   | <u>\$1,104</u>    |
| 113.29 | Instrument calibration service only, <del>less than 100 curies</del>          | 960   | <u>\$1,104</u>    |
| 113.30 | <del>Instrument calibration service only, 100 curies or more</del>            |       | <del>960</del>    |
| 113.31 | Service, maintenance, installation, source changes, etc.                      | 2,640 | <u>\$3,036</u>    |
| 113.32 | Waste disposal service, prepackaged only                                      | 2,240 | <u>\$2,576</u>    |
| 113.33 | Waste disposal  | 1,520 | <u>\$1,748</u>    |
| 113.34 | Distribution - general licensed devices (sealed sources)                      | 880   | <u>\$1,012</u>    |
| 113.35 | Distribution - general licensed material (unsealed sources)                   | 520   | <u>\$598</u>      |
| 113.36 | Industrial radiography - fixed <u>or temporary</u> location                   | 2,640 | <u>\$3,036</u>    |
| 113.37 | <del>Industrial radiography—temporary job sites</del>                         |       | <del>2,640</del>  |
| 113.38 | Irradiators, self-shielding, <del>less than 10,000 curies</del>               | 1,440 | <u>\$1,656</u>    |
| 113.39 | Irradiators, other, less than 10,000 curies                                   | 2,960 | <u>\$3,404</u>    |
| 113.40 | <del>Irradiators, self-shielding, 10,000 curies or more</del>                 |       | <del>1,440</del>  |

|        |  |       |                |
|--------|--|-------|----------------|
| 114.1  | Research and development - type A, B, or C broad scope         | 4,960 | <u>\$5,704</u> |
| 114.2  | <del>Research and development - type B broad scope</del>       |       | 4,960          |
| 114.3  | <del>Research and development - type C broad scope</del>       |       | 4,960          |
| 114.4  | Research and development - other                               | 2,400 | <u>\$2,760</u> |
| 114.5  | Storage - no operations  | 960   | <u>\$1,104</u> |
| 114.6  | Source material - shielding                                    | 136   | <u>\$156</u>   |
| 114.7  | Special nuclear material plutonium - neutron source in device  | 1,200 | <u>\$1,380</u> |
| 114.8  | Pacemaker by-product and/or special nuclear material - medical | 1,200 | <u>\$1,380</u> |
| 114.9  | (institution)  |       |                |
| 114.10 | Pacemaker by-product and/or special nuclear material -         | 2,320 | <u>\$2,668</u> |
| 114.11 | manufacturing and distribution                                 |       |                |
| 114.12 | Accelerator-produced radioactive material                      | 4,100 | <u>\$4,715</u> |
| 114.13 | Nonprofit educational institutions                             | 300   | <u>\$345</u>   |
| 114.14 | <del>General license registration</del>                        |       | 0              |
| 114.15 | <del>Industrial radiographer certification</del>               |       | 150            |

114.16 Sec. 10. Minnesota Statutes 2020, section 144.1205, subdivision 8, is amended to read:

114.17 Subd. 8. **Reciprocity fee.** A licensee submitting an application for reciprocal recognition  
 114.18 of a materials license issued by another agreement state or the United States Nuclear  
 114.19 Regulatory Commission for a period of 180 days or less during a calendar year must pay  
 114.20 ~~\$1,200~~ \$2,400. For a period of 181 days or more, the licensee must obtain a license under  
 114.21 subdivision 4.

114.22 Sec. 11. Minnesota Statutes 2020, section 144.1205, subdivision 9, is amended to read:

114.23 Subd. 9. **Fees for license amendments.** A licensee must pay a fee of ~~\$300~~ \$600 to  
 114.24 amend a license as follows:

114.25 (1) to amend a license requiring review including, but not limited to, addition of isotopes,  
 114.26 procedure changes, new authorized users, or a new radiation safety officer; and

114.27 (2) to amend a license requiring review and a site visit including, but not limited to,  
 114.28 facility move or addition of processes.

114.29 Sec. 12. Minnesota Statutes 2020, section 144.1205, is amended by adding a subdivision  
 114.30 to read:

114.31 Subd. 10. **Fees for general license registrations.** A person required to register generally  
 114.32 licensed devices according to Minnesota Rules, part 4731.3215, must pay an annual  
 114.33 registration fee of \$450.

115.1 Sec. 13. Minnesota Statutes 2020, section 144.125, subdivision 1, is amended to read:

115.2 Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative officer  
115.3 or other person in charge of each institution caring for infants 28 days or less of age, (2) the  
115.4 person required in pursuance of the provisions of section 144.215, to register the birth of a  
115.5 child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have  
115.6 administered to every infant or child in its care tests for heritable and congenital disorders  
115.7 according to subdivision 2 and rules prescribed by the state commissioner of health.

115.8 (b) Testing, recording of test results, reporting of test results, and follow-up of infants  
115.9 with heritable congenital disorders, including hearing loss detected through the early hearing  
115.10 detection and intervention program in section 144.966, shall be performed at the times and  
115.11 in the manner prescribed by the commissioner of health.

115.12 (c) The fee to support the newborn screening program, including tests administered  
115.13 under this section and section 144.966, shall be ~~\$135~~ \$177 per specimen. This fee amount  
115.14 shall be deposited in the state treasury and credited to the state government special revenue  
115.15 fund.

115.16 (d) The fee to offset the cost of the support services provided under section 144.966,  
115.17 subdivision 3a, shall be \$15 per specimen. This fee shall be deposited in the state treasury  
115.18 and credited to the general fund.

115.19 Sec. 14. Minnesota Statutes 2020, section 145.901, is amended to read:

115.20 **145.901 MATERNAL MORBIDITY AND DEATH STUDIES.**

115.21 Subdivision 1. **Purpose.** The commissioner of health may conduct maternal morbidity  
115.22 and death studies to assist the planning, implementation, and evaluation of medical, health,  
115.23 and welfare service systems and to reduce the numbers of preventable adverse maternal  
115.24 outcomes and deaths in Minnesota.

115.25 Subd. 2. **Access to data.** (a) The commissioner of health has access to medical data as  
115.26 defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined  
115.27 in section 13.83, subdivision 1, and health records created, maintained, or stored by providers  
115.28 as defined in section 144.291, subdivision 2, paragraph (i), without the consent of the subject  
115.29 of the data, and without the consent of the parent, spouse, other guardian, or legal  
115.30 representative of the subject of the data, when the subject of the data is a woman who died  
115.31 or experienced morbidities during a pregnancy or within 12 months of a fetal death, a live  
115.32 birth, or other termination of a pregnancy.

116.1 The commissioner has access only to medical data and health records related to maternal  
116.2 morbidity and deaths that occur on or after July 1, 2000, including the names of the providers;  
116.3 clinics; or other health services, such as family home visiting, WIC, prescription drug  
116.4 monitoring programs, and behavioral health services, where care was received before,  
116.5 during, or relating to the pregnancy or death. The commissioner has access to records  
116.6 maintained by the medical examiner, coroner, or hospitals or hospital discharge data for the  
116.7 purpose of providing the name and location of any pre-pregnancy, prenatal, or other care  
116.8 up to one year after the end of the pregnancy received by the subject of the data.

116.9 The subject of the data or the subject's parent, spouse, other guardian, or legal  
116.10 representative may voluntarily participate in an informant interview with staff on behalf of  
116.11 the commissioner related to the maternal experience. If the subject of the data or the subject's  
116.12 parent, spouse, other guardian, or legal representative agrees to an interview, the  
116.13 commissioner may compensate the interviewee for time and other expenses related to the  
116.14 interview.

116.15 (b) The provider or responsible authority that creates, maintains, or stores the data shall  
116.16 furnish the data upon the request of the commissioner. The provider or responsible authority  
116.17 may charge a fee for providing the data, not to exceed the actual cost of retrieving and  
116.18 duplicating the data.

116.19 (c) The commissioner shall make a good faith reasonable effort to notify the subject of  
116.20 the data, or the subject's parent, spouse, other guardian, or legal representative of the subject  
116.21 of the data before collecting data on the subject. For purposes of this paragraph, "reasonable  
116.22 effort" means one notice is sent by certified mail to the last known address of the subject  
116.23 of the data, or the subject's parent, spouse, guardian, or legal representative informing the  
116.24 recipient of the data collection and offering a public health nurse support visit if desired.

116.25 (d) The commissioner does not have access to coroner or medical examiner data that  
116.26 are part of an active investigation as described in section 13.83.

116.27 (e) The commissioner may request and receive from a coroner or medical examiner the  
116.28 name of the health care provider that provided prenatal, postpartum, and other health services  
116.29 to the subject of the data.

116.30 (f) The commissioner may access Department of Human Services data to identify sources  
116.31 of care and services to assist with the evaluation of welfare systems, including housing and  
116.32 Healthy Start, to reduce preventable maternal deaths.

116.33 (g) The commissioner may request and receive law enforcement reports or incident  
116.34 reports related to the subject of the data.

117.1 Subd. 3. **Management of records.** After the commissioner has collected all data about  
117.2 a subject of a morbidity or maternal death study needed to perform the study, the data from  
117.3 source records obtained under subdivision 2, other than data identifying the subject, must  
117.4 be transferred to separate records to be maintained by the commissioner. Notwithstanding  
117.5 section 138.17, after the data have been transferred, all source records obtained under  
117.6 subdivision 2 possessed by the commissioner must be destroyed.

117.7 Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source  
117.8 records under subdivision 2, including identifying information on individual providers, data  
117.9 subjects, or their children, and data derived by the commissioner under subdivision 3 for  
117.10 the purpose of carrying out maternal morbidity and death studies, are classified as confidential  
117.11 data on individuals or confidential data on decedents, as defined in sections 13.02, subdivision  
117.12 3, and 13.10, subdivision 1, paragraph (a).

117.13 (b) Information classified under paragraph (a) shall not be subject to discovery or  
117.14 introduction into evidence in any administrative, civil, or criminal proceeding. Such  
117.15 information otherwise available from an original source shall not be immune from discovery  
117.16 or barred from introduction into evidence merely because it was utilized by the commissioner  
117.17 in carrying out maternal morbidity and death studies.

117.18 (c) Summary data on maternal morbidity and death studies created by the commissioner,  
117.19 which does not identify individual data subjects or individual providers, shall be public in  
117.20 accordance with section 13.05, subdivision 7.

117.21 (d) Data provided by the commissioner of human services to the commissioner of health  
117.22 under this section retains the same classification the data held when retained by the  
117.23 commissioner of human services, as required under section 13.03, subdivision 4, paragraph  
117.24 (c).

117.25 Sec. 15. **[145.9011] FETAL AND INFANT DEATH STUDIES.**

117.26 Subdivision 1. Purpose. The commissioner of health may conduct fetal and infant death  
117.27 studies to assist the planning, implementation, and evaluation of medical, health, and welfare  
117.28 service systems and to reduce the numbers of preventable fetal and infant deaths in  
117.29 Minnesota.

117.30 Subd. 2. Access to data. (a) The commissioner of health has access to medical data as  
117.31 defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined  
117.32 in section 13.83, subdivision 1, and health records created, maintained, or stored by providers  
117.33 as defined in section 144.291, subdivision 2, paragraph (i), without the consent of the subject

118.1 of the data, and without the consent of the parent, other guardian, or legal representative of  
118.2 the subject of the data, when the subject of the data is:

118.3 (1) a live-born infant that died within the first year of life;

118.4 (2) a fetal death which meets the criteria required for reporting as defined in section  
118.5 144.222; or

118.6 (3) the biological mother of a fetus or infant as described in clause (1) or (2).

118.7 The commissioner has access only to medical data and health records related to fetal or  
118.8 infant deaths that occur on or after July 1, 2000, including the names of the providers and  
118.9 clinics where care was received before, during, or relating to the pregnancy or fetal death  
118.10 or death of the infant. The commissioner has access to records maintained by the medical  
118.11 examiner, coroner, or hospitals for the purpose of providing the name and location of any  
118.12 pre-pregnancy, prenatal, postpartum, or pediatric care received by the subject of the data  
118.13 and biological mother.

118.14 (b) The provider or responsible authority that creates, maintains, or stores the data shall  
118.15 furnish the data upon the request of the commissioner. The provider or responsible authority  
118.16 may charge a fee for providing the data, not to exceed the actual cost of retrieving and  
118.17 duplicating the data.

118.18 (c) The commissioner shall make a good faith reasonable effort to notify the parent,  
118.19 spouse, other guardian, or legal representative of the subject of the data before collecting  
118.20 data on the subject. For purposes of this paragraph, "reasonable effort" means one notice  
118.21 is sent by certified mail to the last-known address of the parent, guardian, or legal  
118.22 representative informing the recipient of the data collection and offering a public health  
118.23 nurse support visit if desired.

118.24 (d) The commissioner does not have access to coroner or medical examiner data that  
118.25 are part of an active investigation as described in section 13.83.

118.26 (e) The commissioner may request and receive from the coroner or medical examiner  
118.27 the name of the health care provider that provided prenatal, postpartum, pediatric, and other  
118.28 health services to the subject of the data and biological mother.

118.29 (f) The commissioner shall have access to Department of Human Services data to identify  
118.30 sources of care and services to assist with evaluation of welfare systems to reduce preventable  
118.31 fetal and infant deaths.

118.32 Subd. 3. **Management of records.** After the commissioner has collected all data on a  
118.33 subject of a fetal or infant death study that is needed to perform the study, the data from

119.1 source records obtained under subdivision 2, other than data identifying the subject, must  
119.2 be transferred to separate records to be maintained by the commissioner. Notwithstanding  
119.3 section 138.17, after the data have been transferred, all source records obtained under  
119.4 subdivision 2 possessed by the commissioner must be destroyed.

119.5 Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source  
119.6 records under subdivision 2, including identifying information on individual providers, data  
119.7 subjects, or their family, and data derived by the commissioner under subdivision 3 for the  
119.8 purpose of carrying out fetal or infant death studies, are classified as confidential data on  
119.9 individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3;  
119.10 and 13.10, subdivision 1, paragraph (a).

119.11 (b) Information classified under paragraph (a) shall not be subject to discovery or  
119.12 introduction into evidence in any administrative, civil, or criminal proceeding. Such  
119.13 information otherwise available from an original source shall not be immune from discovery  
119.14 or barred from introduction into evidence merely because it was utilized by the commissioner  
119.15 in carrying out fetal or infant death studies.

119.16 (c) Summary data on fetal and infant death studies created by the commissioner, which  
119.17 do not identify individual data subjects or individual providers, shall be public in accordance  
119.18 with section 13.05, subdivision 7.

119.19 (d) Data provided by the commissioner of human services to the commissioner of health  
119.20 under this section retains the same classification the data held when retained by the  
119.21 commissioner of human services, as required under section 13.03, subdivision 4, paragraph  
119.22 (c).

119.23 Subd. 5. **Fetal and infant mortality reviews.** The commissioner of health shall convene  
119.24 case review committees to conduct death study reviews, make recommendations, and  
119.25 publicly share summary information, especially for racial and ethnic groups, including  
119.26 American Indians and African Americans, that experience significantly disparate rates of  
119.27 fetal and infant mortality. The case review committees may include but are not limited to  
119.28 medical examiners or coroners, health care institutions that provide care to pregnant people  
119.29 and infants, obstetric and pediatric practitioners, Medicaid representatives, state agency  
119.30 women and infant program representatives, and individuals from the communities with  
119.31 disparate rates and other subject matter experts as appropriate. The case review committees  
119.32 shall review data from source records obtained under subdivision 2, other than data  
119.33 identifying the subject or the provider. Every three years beginning December 1, 2022, the  
119.34 case review committees shall provide findings and recommendations to the Maternal and

120.1 Child Health Advisory Task Force and the commissioner from review of fetal and infant  
 120.2 deaths and provide specific recommendations designed to reduce disparities in fetal and  
 120.3 infant deaths.

120.4 Subd. 6. **Community action committees.** (a) The commissioner shall convene  
 120.5 community action committees to implement the priority recommendations from the case  
 120.6 review committees.

120.7 (b) Members of the community action committees may include but are not limited to  
 120.8 local, tribal, and state government representatives; local hospital or health care administration;  
 120.9 local public health; nonprofit organizations serving the community's mothers, infants, and  
 120.10 fathers; state maternal and child health consultants; case review committee members;  
 120.11 representatives of communities disproportionately affected by fetal and infant death;  
 120.12 Minnesotans with lived experiences; and others based on recommendations.

120.13 Sec. 16. Minnesota Statutes 2020, section 326.71, subdivision 4, is amended to read:

120.14 Subd. 4. **Asbestos-related work.** "Asbestos-related work" means the enclosure, removal,  
 120.15 or encapsulation of asbestos-containing material in a quantity that meets or exceeds 260  
 120.16 linear feet of friable asbestos-containing material on pipes, 160 square feet of friable  
 120.17 asbestos-containing material on other facility components, or, if linear feet or square feet  
 120.18 cannot be measured, a total of 35 cubic feet of friable asbestos-containing material on or  
 120.19 off all facility components in one facility. In the case of single or multifamily residences,  
 120.20 "asbestos-related work" also means the enclosure, removal, or encapsulation of greater than  
 120.21 ten but less than 260 linear feet of friable asbestos-containing material on pipes, greater  
 120.22 than six but less than 160 square feet of friable asbestos-containing material on other facility  
 120.23 components, or, if linear feet or square feet cannot be measured, greater than one cubic foot  
 120.24 but less than 35 cubic feet of friable asbestos-containing material on or off all facility  
 120.25 components in one facility. ~~This provision excludes asbestos-containing floor tiles and~~  
 120.26 ~~sheeting, roofing materials, siding, and all ceilings with asbestos-containing material in~~  
 120.27 ~~single family residences and buildings with no more than four dwelling units.~~

120.28 Asbestos-related work includes asbestos abatement area preparation; enclosure, removal,  
 120.29 or encapsulation operations; and an air quality monitoring specified in rule to assure that  
 120.30 the abatement and adjacent areas are not contaminated with asbestos fibers during the project  
 120.31 and after completion.

120.32 For purposes of this subdivision, the quantity of ~~asbestos-containing~~ material applies  
 120.33 separately for every project.



121.1 Sec. 17. Minnesota Statutes 2020, section 326.75, subdivision 1, is amended to read:

121.2 Subdivision 1. **Licensing fee.** A person required to be licensed under section 326.72  
 121.3 shall, before receipt of the license and before causing asbestos-related work to be performed,  
 121.4 pay the commissioner an annual license fee of ~~\$100~~ \$105.

121.5 Sec. 18. Minnesota Statutes 2020, section 326.75, subdivision 2, is amended to read:

121.6 Subd. 2. **Certification fee.** An individual required to be certified as an asbestos worker  
 121.7 or asbestos site supervisor under section 326.73, subdivision 1, shall pay the commissioner  
 121.8 a certification fee of ~~\$50~~ \$52.50 before the issuance of the certificate. ~~The commissioner~~  
 121.9 ~~may establish by rule fees required before the issuance of~~ An individual required to be  
 121.10 certified as an asbestos inspector, asbestos management planner, and asbestos project  
 121.11 designer certificates required under section 326.73, subdivisions 2, 3, and 4, shall pay the  
 121.12 commissioner a certification fee of \$105 before the issuance of the certificate.

121.13 Sec. 19. Minnesota Statutes 2020, section 326.75, subdivision 3, is amended to read:

121.14 Subd. 3. **Permit fee.** Five calendar days before beginning asbestos-related work, a person  
 121.15 shall pay a project permit fee to the commissioner equal to ~~one~~ two percent of the total costs  
 121.16 of the asbestos-related work. For asbestos-related work performed in single or multifamily  
 121.17 residences, of greater than ten but less than 260 linear feet of asbestos-containing material  
 121.18 on pipes, or greater than six but less than 160 square feet of asbestos-containing material  
 121.19 on other facility components, a person shall pay a project permit fee of \$35 to the  
 121.20 commissioner.

## 121.21 ARTICLE 6

### 121.22 APPROPRIATIONS

121.23 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

121.24 The sums shown in the columns marked "Appropriations" are appropriated to the agencies  
 121.25 and for the purposes specified in this article. The appropriations are from the general fund,  
 121.26 or another named fund, and are available for the fiscal years indicated for each purpose.  
 121.27 The figures "2022" and "2023" used in this article mean that the appropriations listed under  
 121.28 them are available for the fiscal year ending June 30, 2022, or June 30, 2023, respectively.  
 121.29 "The first year" is fiscal year 2022. "The second year" is fiscal year 2023. "The biennium"  
 121.30 is fiscal years 2022 and 2023.

122.1 **APPROPRIATIONS**  
 122.2 **Available for the Year**  
 122.3 **Ending June 30**  
 122.4 **2022** **2023**

122.5 **Sec. 2. COMMISSIONER OF HUMAN**  
 122.6 **SERVICES**

122.7 **Subdivision 1. Total Appropriation** **\$ 4,232,594,000** **\$ 4,385,195,000**

|        |                           | <u>Appropriations by Fund</u> |                      |
|--------|---------------------------|-------------------------------|----------------------|
|        |                           | <u>2022</u>                   | <u>2023</u>          |
| 122.8  |                           |                               |                      |
| 122.9  |                           |                               |                      |
| 122.10 | <u>General</u>            | <u>3,361,282,000</u>          | <u>3,535,836,000</u> |
| 122.11 | <u>State Government</u>   |                               |                      |
| 122.12 | <u>Special Revenue</u>    | <u>4,174,000</u>              | <u>4,174,000</u>     |
| 122.13 | <u>Health Care Access</u> | <u>867,038,000</u>            | <u>845,085,000</u>   |
| 122.14 | <u>Federal TANF</u>       | <u>100,000</u>                | <u>100,000</u>       |

122.15 The amounts that may be spent for each  
 122.16 purpose are specified in the following  
 122.17 subdivisions.

122.18 **Subd. 2. Information Technology**

122.19 **(a) IT Appropriations Generally. This**  
 122.20 **appropriation includes funds for information**  
 122.21 **technology projects, services, and support.**  
 122.22 **Notwithstanding Minnesota Statutes, section**  
 122.23 **16E.0466, funding for information technology**  
 122.24 **project costs shall be incorporated into the**  
 122.25 **service level agreement and paid to the Office**  
 122.26 **of MN.IT Services by the Department of**  
 122.27 **Human Services under the rates and**  
 122.28 **mechanism specified in that agreement.**

122.29 **(b) Receipts for Systems Project.**  
 122.30 **Appropriations and federal receipts for**  
 122.31 **information systems projects for MAXIS,**  
 122.32 **PRISM, MMIS, ISDS, METS, and SSIS must**  
 122.33 **be deposited in the state systems account**

123.1 authorized in Minnesota Statutes, section  
 123.2 256.014. Money appropriated for computer  
 123.3 projects approved by the commissioner of the  
 123.4 Office of MN.IT Services, funded by the  
 123.5 legislature, and approved by the commissioner  
 123.6 of management and budget may be transferred  
 123.7 from one project to another and from  
 123.8 development to operations as the  
 123.9 commissioner of human services considers  
 123.10 necessary. Any unexpended balance in the  
 123.11 appropriation for these projects does not  
 123.12 cancel and is available for ongoing  
 123.13 development and operations.

123.14 **Subd. 3. Central Office; Operations**

| 123.15 | <u>Appropriations by Fund</u> |                                       |
|--------|-------------------------------|---------------------------------------|
| 123.16 | <u>General</u>                | <u>157,188,000</u> <u>161,099,000</u> |
| 123.17 | <u>State Government</u>       |                                       |
| 123.18 | <u>Special Revenue</u>        | <u>4,174,000</u> <u>4,174,000</u>     |
| 123.19 | <u>Health Care Access</u>     | <u>20,709,000</u> <u>20,709,000</u>   |
| 123.20 | <u>Federal TANF</u>           | <u>100,000</u> <u>100,000</u>         |

123.21 **(a) Administrative Recovery; Set-Aside. The**  
 123.22 commissioner may invoice local entities  
 123.23 through the SWIFT accounting system as an  
 123.24 alternative means to recover the actual cost of  
 123.25 administering the following provisions:  
 123.26 (1) Minnesota Statutes, section 125A.744,  
 123.27 subdivision 3;  
 123.28 (2) Minnesota Statutes, section 245.495,  
 123.29 paragraph (b);  
 123.30 (3) Minnesota Statutes, section 256B.0625,  
 123.31 subdivision 20, paragraph (k);  
 123.32 (4) Minnesota Statutes, section 256B.0924,  
 123.33 subdivision 6, paragraph (g);

124.1 (5) Minnesota Statutes, section 256B.0945,  
 124.2 subdivision 4, paragraph (d); and

124.3 (6) Minnesota Statutes, section 256F.10,  
 124.4 subdivision 6, paragraph (b).

124.5 **(b) Base Level Adjustment.** The general fund  
 124.6 base is \$161,781,000 in fiscal year 2024 and  
 124.7 \$161,934,000 in fiscal year 2025.

124.8 **Subd. 4. Central Office; Health Care**

|        |                               |                   |                   |
|--------|-------------------------------|-------------------|-------------------|
| 124.9  | <u>Appropriations by Fund</u> |                   |                   |
| 124.10 | <u>General</u>                | <u>21,942,000</u> | <u>22,360,000</u> |
| 124.11 | <u>Health Care Access</u>     | <u>24,313,000</u> | <u>24,313,000</u> |

124.12 **(a) Case Management Benefit Study for**  
 124.13 **American Indians.** \$200,000 in fiscal year  
 124.14 2022 is for a contract to conduct fiscal analysis  
 124.15 and development of standards for a targeted  
 124.16 case management benefit for American  
 124.17 Indians. The commissioner of human services  
 124.18 must consult the Minnesota Indian Affairs  
 124.19 Council in the development of any request for  
 124.20 proposal and in the evaluation of responses.

124.21 This is a onetime appropriation. Any  
 124.22 unencumbered balance remaining from the  
 124.23 first year does not cancel and is available for  
 124.24 the second year of the biennium.

124.25 **(b) Base Level Adjustment.** The general fund  
 124.26 base is \$23,453,000 in fiscal year 2024 and  
 124.27 \$23,512,000 in fiscal year 2025.

124.28 **Subd. 5. Central Office; Community Supports**

|        |                               |               |            |
|--------|-------------------------------|---------------|------------|
| 124.29 | <u>Appropriations by Fund</u> |               |            |
| 124.30 | <u>General</u>                | <u>30,000</u> | <u>-0-</u> |

124.31 **Subd. 6. Forecasted Programs; MinnesotaCare**                      207,373,000                      184,499,000

124.32 **Generally.** This appropriation is from the  
 124.33 health care access fund.

125.1 **Subd. 7. Forecasted Programs; Medical**  
 125.2 **Assistance**

125.3 Appropriations by Fund

125.4 General                      3,173,949,000    3,340,640,000

125.5 Health Care Access      611,178,000    612,099,000

125.6 **Behavioral Health Services. \$1,000,000 in**  
 125.7 **fiscal year 2022 and \$1,000,000 in fiscal year**  
 125.8 **2023 are for behavioral health services**  
 125.9 **provided by hospitals identified under**  
 125.10 **Minnesota Statutes, section 256.969,**  
 125.11 **subdivision 2b, paragraph (a), clause (4). The**  
 125.12 **increase in payments shall be made by**  
 125.13 **increasing the adjustment under Minnesota**  
 125.14 **Statutes, section 256.969, subdivision 2b,**  
 125.15 **paragraph (e), clause (2).**

125.16 **Subd. 8. Grant Programs; Health Care Grants**

125.17 Appropriations by Fund

125.18 General                      4,811,000      4,811,000

125.19 Health Care Access      3,465,000      3,465,000

125.20 **Integrated Care for High-Risk Pregnant**  
 125.21 **Women Grant Program. \$1,100,000 in fiscal**  
 125.22 **year 2022 and \$1,100,000 in fiscal year 2023**  
 125.23 **are for the integrated care for high-risk**  
 125.24 **pregnant women grant program under**  
 125.25 **Minnesota Statutes, section 256B.79.**

125.26 **Subd. 9. Direct Care and Treatment -**  
 125.27 **Operations**

3,663,000

7,326,000

125.28 Sec. 3. Laws 2017, chapter 13, article 1, section 15, as amended by Laws 2017, First  
 125.29 Special Session chapter 6, article 5, section 10, and Laws 2019, First Special Session chapter  
 125.30 9, article 8, section 19, is amended to read:

125.31 **Sec. 15. MINNESOTA PREMIUM SECURITY PLAN FUNDING.**

125.32 (a) The Minnesota Comprehensive Health Association shall fund the operational and  
 125.33 administrative costs and reinsurance payments of the Minnesota security plan and association

126.1 using the following amounts deposited in the premium security plan account in Minnesota  
 126.2 Statutes, section 62E.25, subdivision 1, in the following order:

- 126.3 (1) any federal funding available;
- 126.4 (2) funds deposited under article 1, sections 12 and 13;
- 126.5 (3) any state funds from the health care access fund; and
- 126.6 (4) any state funds from the general fund.

126.7 (b) The association shall transfer from the premium security plan account any remaining  
 126.8 state funds not used for the Minnesota premium security plan by June 30, 2023, to the  
 126.9 commissioner of commerce. Any amount transferred to the commissioner of commerce  
 126.10 shall be deposited in the ~~health care access fund in Minnesota Statutes, section 16A.724~~  
 126.11 general fund for the fiscal year starting on July 1, 2023.

126.12 (c) The Minnesota Comprehensive Health Association may not spend more than  
 126.13 \$271,000,000 for benefit year 2018 and not more than \$271,000,000 for benefit year 2019  
 126.14 for the operational and administrative costs of, and reinsurance payments under, the  
 126.15 Minnesota premium security plan.

126.16 Sec. 4. **TRANSFERS; HUMAN SERVICES.**

126.17 Subdivision 1. **Grants.** The commissioner of human services, with the approval of the  
 126.18 commissioner of management and budget, may transfer unencumbered appropriation balances  
 126.19 for the biennium ending June 30, 2023, within fiscal years among the MFIP, general  
 126.20 assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota  
 126.21 Statutes, section 119B.05, Minnesota supplemental aid program, group residential housing  
 126.22 program, the entitlement portion of Northstar Care for Children under Minnesota Statutes,  
 126.23 chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment  
 126.24 fund, and between fiscal years of the biennium. The commissioner shall inform the chairs  
 126.25 and ranking minority members of the senate Health and Human Services Finance Division  
 126.26 and the house of representatives Health and Human Services Finance Committee quarterly  
 126.27 about transfers made under this subdivision.

126.28 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money  
 126.29 may be transferred within the Department of Human Services as the commissioners consider  
 126.30 necessary, with the advance approval of the commissioner of management and budget. The  
 126.31 commissioner shall inform the chairs and ranking minority members of the senate Health  
 126.32 and Human Services Finance Division and the house of representatives Health and Human  
 126.33 Services Finance Committee quarterly about transfers made under this subdivision.

127.1 Sec. 5. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

127.2 The commissioners of health and human services shall not use indirect cost allocations  
127.3 to pay for the operational costs of any program for which they are responsible.

127.4 Sec. 6. **EXPIRATION OF UNCODIFIED LANGUAGE.**

127.5 All uncodified language contained in this article expires on June 30, 2023, unless a  
127.6 different expiration date is explicit.

127.7 Sec. 7. **EFFECTIVE DATE.**

127.8 This article is effective July 1, 2021, unless a different effective date is specified.

**245C.10 BACKGROUND STUDY; FEES.**

Subd. 2. **Supplemental nursing services agencies.** The commissioner shall recover the cost of the background studies initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1, through a fee of no more than \$20 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 2a. **Occupations regulated by commissioner of health.** The commissioner shall set fees to recover the cost of combined background studies and criminal background checks initiated by applicants, licensees, and certified practitioners regulated under sections 148.511 to 148.5198 and chapter 153A. The fees collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks.

Subd. 3. **Personal care provider organizations.** The commissioner shall recover the cost of background studies initiated by a personal care provider organization under sections 256B.0651 to 256B.0654 and 256B.0659 through a fee of no more than \$20 per study charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 4. **Temporary personnel agencies, educational programs, and professional services agencies.** The commissioner shall recover the cost of the background studies initiated by temporary personnel agencies, educational programs, and professional services agencies that initiate background studies under section 245C.03, subdivision 4, through a fee of no more than \$20 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 5. **Adult foster care and family adult day services.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for the purposes of adult foster care and family adult day services licensing, through a fee of no more than \$20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** The commissioner shall recover the cost of background studies initiated by unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities under section 256B.4912 through a fee of no more than \$20 per study.

Subd. 7. **Private agencies.** The commissioner shall recover the cost of conducting background studies under section 245C.33 for studies initiated by private agencies for the purpose of adoption through a fee of no more than \$70 per study charged to the private agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 8. **Children's therapeutic services and supports providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 7, for the purposes of children's therapeutic services and supports under section 256B.0943, through a fee of no more than \$20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for all programs that are licensed by the commissioner, except child foster care when the applicant or license holder resides in the home where child foster care services are provided, family child care, child care centers, certified license-exempt child care centers, and legal nonlicensed child care authorized under chapter 119B, through a fee of no more than \$20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 9a. **Child care programs.** The commissioner shall recover the cost of a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care providers authorized under chapter 119B through a fee of no more than \$40 per study charged to the license holder. A fee of no more than \$20 per study shall be charged for studies conducted under section 245C.05, subdivision 5a, paragraph (a). The fees collected under this subdivision are appropriated to the commissioner to conduct background studies.



Subd. 10. **Community first services and supports organizations.** The commissioner shall recover the cost of background studies initiated by an agency-provider delivering services under section 256B.85, subdivision 11, or a financial management services provider providing service functions under section 256B.85, subdivision 13, through a fee of no more than \$20 per study, charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 11. **Providers of housing support.** The commissioner shall recover the cost of background studies initiated by providers of housing support under section 256I.04 through a fee of no more than \$20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 12. **Child protection workers or social services staff having responsibility for child protective duties.** The commissioner shall recover the cost of background studies initiated by county social services agencies and local welfare agencies for individuals who are required to have a background study under section 626.559, subdivision 1b, through a fee of no more than \$20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 13. **Providers of special transportation service.** The commissioner shall recover the cost of background studies initiated by providers of special transportation service under section 174.30 through a fee of no more than \$20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 14. **Children's residential facilities.** The commissioner shall recover the cost of background studies initiated by a licensed children's residential facility through a fee of no more than \$51 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Subd. 16. **Providers of housing support services.** The commissioner shall recover the cost of background studies initiated by providers of housing support services under section 256B.051 through a fee of no more than \$20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

#### **256B.0625 COVERED SERVICES.**

Subd. 18c. **Nonemergency Medical Transportation Advisory Committee.** (a) The Nonemergency Medical Transportation Advisory Committee shall advise the commissioner on the administration of nonemergency medical transportation covered under medical assistance. The advisory committee shall meet at least quarterly the first year following January 1, 2015, and at least biannually thereafter and may meet more frequently as required by the commissioner. The advisory committee shall annually elect a chair from among its members, who shall work with the commissioner or the commissioner's designee to establish the agenda for each meeting. The commissioner, or the commissioner's designee, shall attend all advisory committee meetings.

(b) The Nonemergency Medical Transportation Advisory Committee shall advise and make recommendations to the commissioner on:

- (1) updates to the nonemergency medical transportation policy manual;
- (2) other aspects of the nonemergency medical transportation system, as requested by the commissioner; and
- (3) other aspects of the nonemergency medical transportation system, as requested by:
  - (i) a committee member, who may request an item to be placed on the agenda for a future meeting. The request may be considered by the committee and voted upon. If the motion carries, the meeting agenda item may be developed for presentation to the committee; and
  - (ii) a member of the public, who may approach the committee by letter or e-mail requesting that an item be placed on a future meeting agenda. The request may be considered by the committee and voted upon. If the motion carries, the agenda item may be developed for presentation to the committee.

(c) The Nonemergency Medical Transportation Advisory Committee shall coordinate its activities with the Minnesota Council on Transportation Access established under section 174.285. The chair of the advisory committee, or the chair's designee, shall attend all meetings of the Minnesota Council on Transportation Access.

APPENDIX  
Repealed Minnesota Statutes: 21-03536

(d) The Nonemergency Medical Transportation Advisory Committee shall expire December 1, 2019.

Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical Transportation Advisory Committee consists of:

(1) four voting members who represent counties, utilizing the rural urban commuting area classification system. As defined in subdivision 17, these members shall be designated as follows:

- (i) two counties within the 11-county metropolitan area;
- (ii) one county representing the rural area of the state; and
- (iii) one county representing the super rural area of the state.

The Association of Minnesota Counties shall appoint one county within the 11-county metropolitan area and one county representing the super rural area of the state. The Minnesota Inter-County Association shall appoint one county within the 11-county metropolitan area and one county representing the rural area of the state;

(2) three voting members who represent medical assistance recipients, including persons with physical and developmental disabilities, persons with mental illness, seniors, children, and low-income individuals;

(3) five voting members who represent providers that deliver nonemergency medical transportation services to medical assistance enrollees, one of whom is a taxicab owner or operator;

(4) two voting members of the house of representatives, one from the majority party and one from the minority party, appointed by the speaker of the house, and two voting members from the senate, one from the majority party and one from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(5) one voting member who represents demonstration providers as defined in section 256B.69, subdivision 2;

(6) one voting member who represents an organization that contracts with state or local governments to coordinate transportation services for medical assistance enrollees;

(7) one voting member who represents the Minnesota State Council on Disability;

(8) the commissioner of transportation or the commissioner's designee, who shall serve as a voting member;

(9) one voting member appointed by the Minnesota Ambulance Association; and

(10) one voting member appointed by the Minnesota Hospital Association.

(b) Members of the advisory committee shall not be employed by the Department of Human Services. Members of the advisory committee shall receive no compensation.

Subd. 18e. **Single administrative structure and delivery system.** The commissioner, in coordination with the commissioner of transportation, shall implement a single administrative structure and delivery system for nonemergency medical transportation, beginning the latter of the date the single administrative assessment tool required in this subdivision is available for use, as determined by the commissioner or by July 1, 2016.

In coordination with the Department of Transportation, the commissioner shall develop and authorize a web-based single administrative structure and assessment tool, which must operate 24 hours a day, seven days a week, to facilitate the enrollee assessment process for nonemergency medical transportation services. The web-based tool shall facilitate the transportation eligibility determination process initiated by clients and client advocates; shall include an accessible automated intake and assessment process and real-time identification of level of service eligibility; and shall authorize an appropriate and auditable mode of transportation authorization. The tool shall provide a single framework for reconciling trip information with claiming and collecting complaints regarding inappropriate level of need determinations, inappropriate transportation modes utilized, and interference with accessing nonemergency medical transportation. The web-based single administrative structure shall operate on a trial basis for one year from implementation and, if approved by the commissioner, shall be permanent thereafter. The commissioner shall seek input from the Nonemergency Medical Transportation Advisory Committee to ensure the software is effective and user-friendly and make recommendations regarding funding of the single administrative system.

APPENDIX  
Repealed Minnesota Statutes: 21-03536

Subd. 18h. **Managed care.** (a) The following subdivisions apply to managed care plans and county-based purchasing plans:

- (1) subdivision 17, paragraphs (a), (b), (i), and (n);
- (2) subdivision 18; and
- (3) subdivision 18a.

(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service specified in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

**256L.11 PROVIDER PAYMENT.**

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