SENATE
STATE OF MINNESOTA
NINETY-SECOND SESSION

S.F. No. 2360

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DATE	D-PG	OFFICIAL STATUS
04/06/2021	1215	Introduction and first reading Referred to Health and Human Services Finance and Policy
04/07/2021	1313	Authors added Abeler; Draheim
04/12/2021		Comm report: To pass as amended and re-refer to Finance

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

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

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

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

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

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

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

(3) the person's assets are no more than (i) $10,000 for a single individual, or (ii) $18,000 for a married couple or family of two or more; or, when the resource limits for eligibility for the Medicare Part D extra help low income subsidy (LIS) exceed either amount in item (i) or (ii), the person's assets are no more than the LIS resource limit in United States Code, 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

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

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

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

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

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

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

(3) the nursing staff:

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

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

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications 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 5f~~, 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

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

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

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

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

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

EFFECTIVE DATE. This section is effective upon federal approval.

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

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

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

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the 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.

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

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

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

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

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.

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

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

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

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

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

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

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

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

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600
125 to 149 persons	$700
150 to 174 persons	$800
175 to 199 persons	$900
200 to 224 persons	$1,000
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:

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

greater than $1,250,000 but less than or equal to $1,500,000	$3,750
greater than $1,500,000 but less than or equal to $1,750,000	$4,000
greater than $1,750,000 but less than or equal to $2,000,000	$4,250
greater than $2,000,000 but less than or equal to $2,500,000	$4,500
greater than $2,500,000 but less than or equal to $3,000,000	$4,750
greater than $3,000,000 but less than or equal to $3,500,000	$5,000
greater than $3,500,000 but less than or equal to $4,000,000	$5,500
greater than $4,000,000 but less than or equal to $4,500,000	$6,000
greater than $4,500,000 but less than or equal to $5,000,000	$6,500
greater than $5,000,000 but less than or equal to $7,500,000	$7,000
greater than $7,500,000 but less than or equal to $10,000,000	$8,500
greater than $10,000,000 but less than or equal to $12,500,000	$10,000
greater than $12,500,000 but less than or equal to $15,000,000	$14,000
greater than $15,000,000	$18,000

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

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

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

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

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

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

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

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

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

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

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

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

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

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

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

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

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

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

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

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900
75 to 99 persons	$1,100
100 or more persons	$1,300

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

(l) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of $1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the 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.

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

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

(1) every individual who applies for certification;

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

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

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

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

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

(1) owners who have a five percent interest or more and all managing employees are subject to a background study under this chapter. This requirement applies to currently 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:

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

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

(3) current zip code;

(4) sex;

(5) date of birth;

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

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

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

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

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

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

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

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

(b) The information collected under subdivision 1 about an individual who is the subject of a completed background study may only be viewable by an entity that initiates a 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;

(7) monitoring of access to dental services;

(8) performance measurement;

(9) quality improvement and evaluation requirements; and

(10) management of third-party liability requirements.

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

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

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

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

~~The rules shall provide:~~

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

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

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

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

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

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

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

(1) eyeglasses;

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

(3) hearing aids and supplies; and

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

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

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

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

(6) drugs.

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

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for ~~special transportation services or~~ 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;

(2) general anesthesia; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance 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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(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)~~ <u>(k)</u> 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)~~ <u>(h)</u> 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 <u>nonemergency</u>
67.20 <u>medical transportation vendor or</u> 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

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

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

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

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

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

(ix) whether the service was ambulatory or nonambulatory;

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

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

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

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

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

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

Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude ~~or modify~~ coverage for outpatient prescription drugs dispensed by a pharmacy to a member eligible for medical assistance under this chapter from the prepaid managed care contracts entered into under this section ~~in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage 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

		2022	2023
78.22			
78.23	General	132,347,000	132,324,000
78.24–78.25	State Government Special Revenue	68,451,000	68,835,000
78.26	Health Care Access	37,512,000	36,832,000
78.27	Federal TANF	11,713,000	11,713,000

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**

Appropriations by Fund		
General	95,690,000	95,877,000
State Government Special Revenue	9,140,000	9,140,000
Health Care Access	37,512,000	36,832,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 in fiscal year 2022 and $3,579,000 in fiscal year 2023 are from the TANF fund for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2022 and $4,978,000 in fiscal year 2023 are from the TANF fund for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding in each fiscal year must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding in each fiscal year must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 in fiscal year 2022 and $1,156,000 in fiscal year 2023 are from the

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 Appropriations by Fund

81.17	General	25,087,000	24,868,000
81.18 81.19	State Government Special Revenue	59,311,000	59,695,000

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 Appropriations by Fund

81.30 81.31	State Government Special Revenue	27,431,000	26,867,000
81.32	Health Care Access	76,000	76,000

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 Subd. 2. **Board of Chiropractic Examiners**	666,000	666,000
82.5 Subd. 3. **Board of Dentistry**	4,228,000	3,753,000

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	Subd. 9. **Board of Optometry**		238,000	238,000
84.2	Subd. 10. **Board of Pharmacy**		4,479,000	4,479,000

84.3 Appropriations by Fund

84.4-84.5	State Government Special Revenue	4,403,000	4,403,000
84.6	Health Care Access	76,000	76,000

84.7 The base for this appropriation in the health
84.8 care access fund is $76,000 in fiscal year 2024,
84.9 $38,000 in fiscal year 2025, and $0 in fiscal
84.10 year 2026.

84.11	Subd. 11. **Board of Physical Therapy**		564,000	564,000
84.12	Subd. 12. **Board of Podiatric Medicine**		214,000	214,000
84.13	Subd. 13. **Board of Psychology**		1,355,000	1,355,000
84.14	Subd. 14. **Board of Social Work**		1,556,000	1,559,000
84.15	Subd. 15. **Board of Veterinary Medicine**		363,000	363,000
84.16-84.17	Subd. 16. **Board of Behavioral Health and Therapy**		868,000	868,000
84.18-84.19	Subd. 17. **Board of Occupational Therapy Practice**		456,000	456,000
84.20-84.21	Sec. 4. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD**	**$**	**3,803,000**	**$ 3,829,000**

84.22 (a) **Cooper/Sams Volunteer Ambulance**
84.23 **Program.** $950,000 in fiscal year 2022 and
84.24 $950,000 in fiscal year 2023 are for the
84.25 Cooper/Sams volunteer ambulance program
84.26 under Minnesota Statutes, section 144E.40.

84.27 (1) Of this amount, $861,000 in fiscal year
84.28 2022 and $861,000 in fiscal year 2023 are for
84.29 the ambulance service personnel longevity
84.30 award and incentive program under Minnesota
84.31 Statutes, section 144E.40.

84.32 (2) Of this amount, $89,000 in fiscal year 2022
84.33 and $89,000 in fiscal year 2023 are for the

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 86.3	State Government Special Revenue	58,450,000	~~61,367,000~~ <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 86.13	State Government Special Revenue	7,614,000	~~7,558,000~~ <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 90.19	State Government Special Revenue	50,836,000	~~53,809,000~~ 52,234,000

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.~~

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

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

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

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

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

(3) recommendations for encouraging use of innovative health care applications using information technology and systems to improve patient care and reduce the cost of care, including applications relating to disease management and personal health management that enable remote monitoring of patients' conditions, especially those with chronic conditions; and

(4) other related issues as requested by the commissioner.

(b) The members of the e-Health Advisory Committee shall include the commissioners, or commissioners' designees, of health, human services, administration, and commerce and additional members to be appointed by the commissioner to include persons representing Minnesota's local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise in health information technology, and other stakeholders as identified by the commissioner to fulfill the requirements of section 3013, paragraph (g), of the HITECH Act.

(c) ~~The commissioner shall prepare and issue an annual report not later than January 30 of each year outlining progress to date in implementing a statewide health information infrastructure and recommending action on policy and necessary resources to continue the promotion of adoption and effective use of health information technology.~~

~~(d)~~ This subdivision expires June 30, 2021.

Sec. 3. Minnesota Statutes 2020, section 62J.495, subdivision 3, is amended to read:

Subd. 3. **Interoperable electronic health record requirements.** (a) Hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(b) The electronic health record must be a qualified electronic health record.

(c) The electronic health record must be certified by the Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(d) The electronic health record must meet the standards established according to section 3004 of the HITECH Act as applicable.

(e) The electronic health record must have the ability to generate information on clinical quality measures and other measures reported under sections 4101, 4102, and 4201 of the HITECH Act.

(f) The electronic health record system must be connected to a state-certified health information organization either directly or through a connection facilitated by a ~~state-certified~~ health data intermediary as defined in section 62J.498.

(g) A health care provider who is a prescriber or dispenser of legend drugs must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 4. Minnesota Statutes 2020, section 62J.495, subdivision 4, is amended to read:

Subd. 4. **Coordination with national HIT activities.** (a) The commissioner, in consultation with the e-Health Advisory Committee, shall update the statewide implementation plan required under subdivision 2 and released June 2008, to be consistent with the updated federal ~~HIT Strategic Plan released by the Office of the National Coordinator in accordance with section 3001 of the HITECH Act. The statewide plan shall meet the requirements for a plan required under section 3013 of the HITECH Act~~ plans.

(b) The commissioner, in consultation with the e-Health Advisory Committee, shall work to ensure coordination between state, regional, and national efforts to support and accelerate efforts to effectively use health information technology to improve the quality

and coordination of health care and the continuity of patient care among health care providers, to reduce medical errors, to improve population health, to reduce health disparities, and to reduce chronic disease. The commissioner's coordination efforts shall include but not be limited to:

~~(1) assisting in the development and support of health information technology regional extension centers established under section 3012(c) of the HITECH Act to provide technical assistance and disseminate best practices;~~

~~(2) providing supplemental information to the best practices gathered by regional centers to ensure that the information is relayed in a meaningful way to the Minnesota health care community;~~

~~(3)~~ (1) providing financial and technical support to Minnesota health care providers to encourage implementation of admission, discharge and transfer alerts, and care summary document exchange transactions and to evaluate the impact of health information technology on cost and quality of care. Communications about available financial and technical support shall include clear information about the interoperable health record requirements in subdivision 1, including a separate statement in bold-face type clarifying the exceptions to those requirements;

~~(4)~~ (2) providing educational resources and technical assistance to health care providers and patients related to state and national privacy, security, and consent laws governing clinical health information, including the requirements in sections 144.291 to 144.298. In carrying out these activities, the commissioner's technical assistance does not constitute legal advice;

~~(5)~~ (3) assessing Minnesota's legal, financial, and regulatory framework for health information exchange, including the requirements in sections 144.291 to 144.298, and making recommendations for modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable; and

~~(6)~~ (4) seeking public input on both patient impact and costs associated with requirements related to patient consent for release of health records for the purposes of treatment, payment, and health care operations, as required in section 144.293, subdivision 2. The commissioner shall provide a report to the legislature on the findings of this public input process no later than February 1, 2017.

(c) The commissioner, in consultation with the e-Health Advisory Committee, shall monitor national activity related to health information technology and shall coordinate

statewide input on policy development. The commissioner shall coordinate statewide responses to proposed federal health information technology regulations in order to ensure that the needs of the Minnesota health care community are adequately and efficiently addressed in the proposed regulations. The commissioner's responses may include, but are not limited to:

(1) reviewing and evaluating any standard, implementation specification, or certification criteria proposed by the national HIT standards ~~committee~~ committees;

(2) reviewing and evaluating policy proposed by ~~the~~ national HIT policy ~~committee~~ committees relating to the implementation of a nationwide health information technology infrastructure; and

(3) ~~monitoring and responding to activity related to the development of quality measures and other measures as required by section 4101 of the HITECH Act. Any response related to quality measures shall consider and address the quality efforts required under chapter 62U; and~~

~~(4)~~ monitoring and responding to national activity related to privacy, security, and data stewardship of electronic health information and individually identifiable health information.

(d) To the extent that the state is either required or allowed to apply, or designate an entity to apply for or carry out activities and programs ~~under section 3013 of the HITECH Act~~, the commissioner of health, in consultation with the e-Health Advisory Committee and the commissioner of human services, shall be the lead applicant or sole designating authority. The commissioner shall make such designations consistent with the goals and objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

(e) The commissioner of human services shall apply for funding necessary to administer the incentive payments to providers authorized under title IV of the American Recovery and Reinvestment Act.

~~(f) The commissioner shall include in the report to the legislature information on the activities of this subdivision and provide recommendations on any relevant policy changes that should be considered in Minnesota.~~

Sec. 5. Minnesota Statutes 2020, section 62J.498, is amended to read:

62J.498 HEALTH INFORMATION EXCHANGE.

Subdivision 1. **Definitions.** (a) The following definitions apply to sections 62J.498 to 62J.4982:

(b) "Clinical data repository" means a real time database that consolidates data from a variety of clinical sources to present a unified view of a single patient and is used by a ~~state-certified~~ health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include clinical data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

(c) "Clinical transaction" means any meaningful use transaction or other health information exchange transaction that is not covered by section 62J.536.

(d) "Commissioner" means the commissioner of health.

(e) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(f) "Health data intermediary" means an entity that provides the technical capabilities or related products and services to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This includes but is not limited to health information service providers (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries as defined in section 62J.495.

(g) "Health information exchange" means the electronic transmission of health-related information between organizations according to nationally recognized standards.

(h) "Health information exchange service provider" means a health data intermediary or health information organization.

(i) "Health information organization" means an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k), to improve coordination of patient care and the efficiency of health care delivery.

~~(j) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act as defined in section 62J.495.~~

~~(k)~~ (j) "Major participating entity" means:

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health 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 ~~(l)~~ (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,

a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

~~(p)~~ (m) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of clinical transactions.

~~(q) "State-certified health data intermediary" means a health data intermediary that has been issued a certificate of authority to operate in Minnesota.~~

~~(r)~~ (n) "State-certified health information organization" means a health information organization that has been issued a certificate of authority to operate in Minnesota.

Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from ~~health data intermediaries and~~ health information organizations for certificates of authority to operate in Minnesota;

(2) require information to be provided as needed from health information exchange service providers in order to meet requirements established under sections 62J.498 to 62J.4982;

~~(2)~~ (3) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

~~(3)~~ (4) respond to public complaints related to health information exchange services;

~~(4)~~ (5) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

~~(5)~~ (6) provide a biennial report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information 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

(11) the organization uses financial policies and procedures consistent with generally accepted accounting principles and has an independent audit of the organization's financials on an annual basis.

(d) Health information organizations that have obtained a certificate of authority must:

(1) meet the requirements established for connecting to the National eHealth Exchange;

(2) annually submit strategic and operational plans for review by the commissioner that address:

(i) progress in achieving objectives included in previously submitted strategic and operational plans across the following domains: business and technical operations, technical infrastructure, legal and policy issues, finance, and organizational governance;

(ii) plans for ensuring the necessary capacity to support clinical transactions;

(iii) approach for attaining financial sustainability, including public and private financing strategies, and rate structures;

(iv) rates of adoption, utilization, and transaction volume, and mechanisms to support health information exchange; and

(v) an explanation of methods employed to address the needs of community clinics, critical access hospitals, and free clinics in accessing health information exchange services;

(3) enter into reciprocal agreements with all other state-certified health information organizations ~~and state-certified health data intermediaries~~ to enable access to patient data, and for the transmission and receipt of clinical transactions. Reciprocal agreements must meet the requirements in subdivision 5;

(4) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability ~~between state-certified health information organizations and state-certified health data intermediaries~~; and

(5) comply with additional requirements for the certification or recertification of health information organizations that may be established by the commissioner.

Subd. 4. **Application for certificate of authority for health information ~~exchange service providers~~ organizations.** (a) Each application for a certificate of authority shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant. Each application shall include the following in addition to 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~~

~~provider~~ organization had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information ~~exchange service provider~~ organization to continue to deliver health information exchange services.

The commissioner shall give reasonable notice in writing to the health information ~~exchange service provider~~ organization of the intent to levy the penalty and the reasons for it. A health information ~~exchange service provider~~ organization may have 15 days within which to contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982, according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(b) If the commissioner has reason to believe that a violation of section 62J.4981 or 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved before commencing action under subdivision 2. The commissioner may notify the health information ~~exchange service provider~~ organization and the representatives, or other persons who appear to be involved in the suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives. The purpose of the conference is to attempt to learn the facts about the suspected violation and, if it appears that a violation has occurred or is threatened, to find a way to correct or prevent it. The conference is not governed by any formal procedural requirements, and may be conducted as the commissioner considers appropriate.

(c) The commissioner may issue an order directing a health information ~~exchange service provider~~ organization or a representative of a health information ~~exchange service provider~~ organization to cease and desist from engaging in any act or practice in violation of sections 62J.4981 and 62J.4982.

(d) Within 20 days after service of the order to cease and desist, a health information ~~exchange service provider~~ organization may contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(e) In the event of noncompliance with a cease and desist order issued under this subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey County District Court.

Subd. 2. **Suspension or revocation of certificates of authority.** (a) The commissioner may suspend or revoke a certificate of authority issued to a ~~health data intermediary or~~ health information organization under section 62J.4981 if the commissioner finds that:

(1) the health information ~~exchange service provider~~ organization is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62J.4981, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the health information ~~exchange service provider~~ organization is unable to fulfill its obligations to furnish comprehensive health information exchange services as required under its health information exchange contract;

(3) the health information ~~exchange service provider~~ organization is no longer financially solvent or may not reasonably be expected to meet its obligations to participating entities;

(4) the health information ~~exchange service provider~~ organization has failed to implement the complaint system in a manner designed to reasonably resolve valid complaints;

(5) the health information ~~exchange service provider~~ organization, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misleading, deceptive, or unfair manner;

(6) the continued operation of the health information ~~exchange service provider~~ organization would be hazardous to its participating entities or the patients served by the participating entities; or

(7) the health information ~~exchange service provider~~ organization has otherwise failed to substantially comply with section 62J.4981 or with any other statute or administrative rule applicable to health information exchange service providers, or has submitted false information in any report required under sections 62J.498 to 62J.4982.

(b) A certificate of authority shall be suspended or revoked only after meeting the requirements of subdivision 3.

(c) If the certificate of authority of a health information ~~exchange service provider~~ organization is suspended, the health information ~~exchange service provider~~ organization shall not, during the period of suspension, enroll any additional participating entities, and shall not engage in any advertising or solicitation.

(d) If the certificate of authority of a health information ~~exchange service provider~~ organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may,

by written order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the greatest practical opportunity to access continuing health information exchange services.

Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a) When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, the commissioner shall notify the health information ~~exchange service provider~~ organization in writing stating the grounds for denial, suspension, or revocation and setting a time within 20 days for a hearing on the matter.

(b) After a hearing before the commissioner at which the health information ~~exchange service provider~~ organization may respond to the grounds for denial, suspension, or revocation, or upon the failure of the health information exchange service provider to appear at the hearing, the commissioner shall take action as deemed necessary and shall issue written findings and mail them to the health information ~~exchange service provider~~ organization.

(c) If suspension, revocation, or administrative penalty is proposed according to this section, the commissioner must deliver, or send by certified mail with return receipt requested, to the health information ~~exchange service provider~~ organization written notice of the commissioner's intent to impose a penalty. This notice of proposed determination must include:

(1) a reference to the statutory basis for the penalty;

(2) a description of the findings of fact regarding the violations with respect to which the penalty is proposed;

(3) the nature and amount of the proposed penalty;

(4) any circumstances described in subdivision 1, paragraph (a), that were considered in determining the amount of the proposed penalty;

(5) instructions for responding to the notice, including a statement of the health information ~~exchange service provider's~~ organization's right to a contested case proceeding and a statement that failure to request a contested case proceeding within 30 calendar days permits the imposition of the proposed penalty; and

(6) the address to which the contested case proceeding request must be sent.

Subd. 4. **Coordination.** The commissioner shall, to the extent possible, seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the

certification and recertification of health information ~~exchange service providers~~ organizations when implementing sections 62J.498 to 62J.4982.

Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every health information ~~exchange service provider~~ organization subject to sections 62J.4981 and 62J.4982 as follows:

(1) filing an application for certificate of authority to operate as a health information organization, $7,000; and

(2) ~~filing an application for certificate of authority to operate as a health data intermediary, $7,000;~~

~~(3)~~ annual health information organization certificate fee, $7,000~~; and~~.

~~(4) annual health data intermediary certificate fee, $7,000.~~

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

(c) Administrative monetary penalties imposed under this subdivision shall be credited to an account in the special revenue fund and are appropriated to the commissioner for the purposes of sections 62J.498 to 62J.4982.

Sec. 8. Minnesota Statutes 2020, section 144.1205, subdivision 2, is amended to read:

Subd. 2. **Initial and annual fee.** (a) A licensee must pay an initial fee that is equivalent to the annual fee upon issuance of the initial license.

(b) A licensee must pay an annual fee at least 60 days before the anniversary date of the issuance of the license. The annual fee is as follows:

TYPE	~~ANNUAL~~ LICENSE FEE
Academic broad scope - type A, B, or C	~~$19,920~~ $25,896
~~Academic broad scope - type B~~	~~19,920~~
~~Academic broad scope - type C~~	~~19,920~~
Academic broad scope - type A, B, or C (4-8 locations)	$31,075
Academic broad scope - type A, B, or C (9 or more locations)	$36,254
Medical broad scope - type A	~~19,920~~ $25,896
Medical broad scope- type A (4-8 locations)	$31,075
Medical broad scope- type A (9 or more locations)	$36,254

~~Medical institution - diagnostic and therapeutic~~	~~3,680~~
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$4,784
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (4-8 locations)	$5,740
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (9 or more locations)	$6,697
~~Medical institution - diagnostic (no written directives)~~	~~3,680~~
~~Medical private practice - diagnostic and therapeutic~~	~~3,680~~
~~Medical private practice - diagnostic (no written directives)~~	~~3,680~~
~~Eye applicators~~	~~3,680~~
~~Nuclear medical vans~~	~~3,680~~
~~High dose rate afterloader~~	~~3,680~~
~~Mobile high dose rate afterloader~~	~~3,680~~
~~Medical therapy - other emerging technology~~	~~3,680~~
Teletherapy	~~8,960~~ $11,648
Gamma knife	~~8,960~~ $11,648
Veterinary medicine	~~2,000~~ $2,600
In vitro testing lab	~~2,000~~ $2,600
Nuclear pharmacy	~~8,800~~ $11,440
Nuclear pharmacy (5 or more locations)	$13,728
Radiopharmaceutical distribution (10 CFR 32.72)	~~3,840~~ $4,992
Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~8,800~~ $11,440
Radiopharmaceutical processing and distribution (10 CFR 32.72) (5 or more locations)	$13,728
Medical sealed sources - distribution (10 CFR 32.74)	~~3,840~~ $4,992
Medical sealed sources - processing and distribution (10 CFR 32.74)	~~8,800~~ $11,440
Medical sealed sources - processing and distribution (10 CFR 32.74) (5 or more locations)	$13,728
Well logging - sealed sources	~~3,760~~ $4,888
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~2,000~~ $2,600
~~Measuring systems - portable gauge~~	~~2,000~~
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (4-8 locations)	$3,120

Line	Category	Fee
111.1–111.2	Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (9 or more locations)	$3,640
111.3	X-ray fluorescent analyzer	~~1,520~~ $1,976
111.4	~~Measuring systems - gas chromatograph~~	~~2,000~~
111.5	~~Measuring systems - other~~	~~2,000~~
111.6–111.7	~~Broad scope~~ Manufacturing and distribution - type A broad scope	~~19,920~~ $25,896
111.8–111.9	Manufacturing and distribution - type A broad scope (4-8 locations)	$31,075
111.10–111.11	Manufacturing and distribution - type A broad scope (9 or more locations)	$36,254
111.12–111.13	~~Broad scope~~ Manufacturing and distribution - type B or C broad scope	~~17,600~~ $22,880
111.14	~~Broad scope Manufacturing and distribution - type C~~	~~17,600~~
111.15–111.16	Manufacturing and distribution - type B or C broad scope (4-8 locations)	$27,456
111.17–111.18	Manufacturing and distribution - type B or C broad scope (9 or more locations)	$32,032
111.19	Manufacturing and distribution - other	~~5,280~~ $6,864
111.20	Manufacturing and distribution - other (4-8 locations)	$8,236
111.21	Manufacturing and distribution - other (9 or more locations)	$9,609
111.22–111.23	Nuclear laundry	~~18,640~~ $24,232
111.24	Decontamination services	~~4,960~~ $6,448
111.25	Leak test services only	~~2,000~~ $2,600
111.26	Instrument calibration service only~~, less than 100 curies~~	~~2,000~~ $2,600
111.27	~~Instrument calibration service only, 100 curies or more~~	~~2,000~~
111.28	Service, maintenance, installation, source changes, etc.	~~4,960~~ $6,448
111.29	Waste disposal service, prepackaged only	~~6,000~~ $7,800
111.30–111.31	Waste disposal	~~8,320~~ $10,816
111.32	Distribution - general licensed devices (sealed sources)	~~1,760~~ $2,288
111.33	Distribution - general licensed material (unsealed sources)	~~1,120~~ $1,456
111.34–111.35	Industrial radiography - fixed or temporary location	~~9,840~~ $12,792
111.36	~~Industrial radiography - temporary job sites~~	~~9,840~~
111.37–111.38	Industrial radiography - fixed or temporary location (5 or more locations)	$16,629
111.39	Irradiators, self-shielding~~, less than 10,000 curies~~	~~2,880~~ $3,744
111.40	Irradiators, other, less than 10,000 curies	~~5,360~~ $6,968
111.41	~~Irradiators, self-shielding, 10,000 curies or more~~	~~2,880~~

Research and development - type A, B, or C broad scope	~~9,520~~ $12,376
~~Research and development - type B broad scope~~	~~9,520~~
~~Research and development - type C broad scope~~	~~9,520~~
Research and development - type A, B, or C broad scope (4-8 locations)	$14,851
Research and development - type A, B, or C broad scope (9 or more locations)	$17,326
Research and development - other	~~4,480~~ $5,824
Storage - no operations	~~2,000~~ $2,600
Source material - shielding	~~584~~ $759
Special nuclear material plutonium - neutron source in device	~~3,680~~ $4,784
Pacemaker by-product and/or special nuclear material - medical (institution)	~~3,680~~ $4,784
Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~5,280~~ $6,864
Accelerator-produced radioactive material	~~3,840~~ $4,992
Nonprofit educational institutions	~~300~~ $500
~~General license registration~~	~~150~~

Sec. 9. Minnesota Statutes 2020, section 144.1205, subdivision 4, is amended to read:

Subd. 4. **Initial and renewal application fee.** A licensee must pay an initial and a renewal application fee ~~as follows:~~ according to this subdivision.

TYPE	APPLICATION FEE
Academic broad scope - type A, B, or C	~~$ 5,920~~ $6,808
~~Academic broad scope - type B~~	~~5,920~~
~~Academic broad scope - type C~~	~~5,920~~
Medical broad scope - type A	~~3,920~~ $4,508
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$1,748
~~Medical institution - diagnostic and therapeutic~~	~~1,520~~
~~Medical institution - diagnostic (no written directives)~~	~~1,520~~
~~Medical private practice - diagnostic and therapeutic~~	~~1,520~~
~~Medical private practice - diagnostic (no written directives)~~	~~1,520~~
~~Eye applicators~~	~~1,520~~
~~Nuclear medical vans~~	~~1,520~~
~~High dose rate afterloader~~	~~1,520~~
~~Mobile high dose rate afterloader~~	~~1,520~~

Line	Item	Fee
113.1	~~Medical therapy - other emerging technology~~	~~1,520~~
113.2	Teletherapy	~~5,520~~ $6,348
113.3	Gamma knife	~~5,520~~ $6,348
113.4	Veterinary medicine	~~960~~ $1,104
113.5	In vitro testing lab	~~960~~ $1,104
113.6	Nuclear pharmacy	~~4,880~~ $5,612
113.7	Radiopharmaceutical distribution (10 CFR 32.72)	~~2,160~~ $2,484
113.8–113.9	Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~4,880~~ $5,612
113.10	Medical sealed sources - distribution (10 CFR 32.74)	~~2,160~~ $2,484
113.11–113.12	Medical sealed sources - processing and distribution (10 CFR 32.74)	~~4,880~~ $5,612
113.13	Well logging - sealed sources	~~1,600~~ $1,840
113.14–113.15	Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~960~~ $1,104
113.16	~~Measuring systems - portable gauge~~	~~960~~
113.17	X-ray fluorescent analyzer	~~584~~ $671
113.18	~~Measuring systems - gas chromatograph~~	~~960~~
113.19	~~Measuring systems - other~~	~~960~~
113.20–113.21	~~Broad scope~~ Manufacturing and distribution - type A, B, and C broad scope	~~5,920~~ $6,854
113.22	~~Broad scope manufacturing and distribution - type B~~	~~5,920~~
113.23	~~Broad scope manufacturing and distribution - type C~~	~~5,920~~
113.24	Manufacturing and distribution - other	~~2,320~~ $2,668
113.25–113.26	Nuclear laundry	~~10,080~~ $11,592
113.27	Decontamination services	~~2,640~~ $3,036
113.28	Leak test services only	~~960~~ $1,104
113.29	Instrument calibration service only~~, less than 100 curies~~	~~960~~ $1,104
113.30	~~Instrument calibration service only, 100 curies or more~~	~~960~~
113.31	Service, maintenance, installation, source changes, etc.	~~2,640~~ $3,036
113.32	Waste disposal service, prepackaged only	~~2,240~~ $2,576
113.33	Waste disposal	~~1,520~~ $1,748
113.34	Distribution - general licensed devices (sealed sources)	~~880~~ $1,012
113.35	Distribution - general licensed material (unsealed sources)	~~520~~ $598
113.36	Industrial radiography - fixed or temporary location	~~2,640~~ $3,036
113.37	~~Industrial radiography - temporary job sites~~	~~2,640~~
113.38	Irradiators, self-shielding~~, less than 10,000 curies~~	~~1,440~~ $1,656
113.39	Irradiators, other, less than 10,000 curies	~~2,960~~ $3,404
113.40	~~Irradiators, self-shielding, 10,000 curies or more~~	~~1,440~~

114.1	Research and development - type A, B, or C broad scope	~~4,960~~ $5,704
114.2	~~Research and development - type B broad scope~~	~~4,960~~
114.3	~~Research and development - type C broad scope~~	~~4,960~~
114.4	Research and development - other	~~2,400~~ $2,760
114.5	Storage - no operations	~~960~~ $1,104
114.6	Source material - shielding	~~136~~ $156
114.7	Special nuclear material plutonium - neutron source in device	~~1,200~~ $1,380
114.8 114.9	Pacemaker by-product and/or special nuclear material - medical (institution)	~~1,200~~ $1,380
114.10 114.11	Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~2,320~~ $2,668
114.12	Accelerator-produced radioactive material	~~4,100~~ $4,715
114.13	Nonprofit educational institutions	~~300~~ $345
114.14	~~General license registration~~	~~0~~
114.15	~~Industrial radiographer certification~~	~~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.

Sec. 13. Minnesota Statutes 2020, section 144.125, subdivision 1, is amended to read:

Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health.

(b) Testing, recording of test results, reporting of test results, and follow-up of infants with heritable congenital disorders, including hearing loss detected through the early hearing detection and intervention program in section 144.966, shall be performed at the times and in the manner prescribed by the commissioner of health.

(c) The fee to support the newborn screening program, including tests administered under this section and section 144.966, shall be ~~$135~~ $177 per specimen. This fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

(d) The fee to offset the cost of the support services provided under section 144.966, subdivision 3a, shall be $15 per specimen. This fee shall be deposited in the state treasury and credited to the general fund.

Sec. 14. Minnesota Statutes 2020, section 145.901, is amended to read:

145.901 MATERNAL MORBIDITY AND DEATH STUDIES.

Subdivision 1. **Purpose.** The commissioner of health may conduct maternal morbidity and death studies to assist the planning, implementation, and evaluation of medical, health, and welfare service systems and to reduce the numbers of preventable adverse maternal outcomes and deaths in Minnesota.

Subd. 2. **Access to data.** (a) The commissioner of health has access to medical data as defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined in section 13.83, subdivision 1, and health records created, maintained, or stored by providers as defined in section 144.291, subdivision 2, paragraph (i), without the consent of the subject of the data, and without the consent of the parent, spouse, other guardian, or legal representative of the subject of the data, when the subject of the data is a woman who died or experienced morbidities during a pregnancy or within 12 months of a fetal death, a live 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

Child Health Advisory Task Force and the commissioner from review of fetal and infant deaths and provide specific recommendations designed to reduce disparities in fetal and infant deaths.

Subd. 6. **Community action committees.** (a) The commissioner shall convene community action committees to implement the priority recommendations from the case review committees.

(b) Members of the community action committees may include but are not limited to local, tribal, and state government representatives; local hospital or health care administration; local public health; nonprofit organizations serving the community's mothers, infants, and fathers; state maternal and child health consultants; case review committee members; representatives of communities disproportionately affected by fetal and infant death; Minnesotans with lived experiences; and others based on recommendations.

Sec. 16. Minnesota Statutes 2020, section 326.71, subdivision 4, is amended to read:

Subd. 4. **Asbestos-related work.** "Asbestos-related work" means the enclosure, removal, or encapsulation of asbestos-containing material in a quantity that meets or exceeds 260 linear feet of friable asbestos-containing material on pipes, 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, a total of 35 cubic feet of friable asbestos-containing material on or off all facility components in one facility. In the case of single or multifamily residences, "asbestos-related work" also means the enclosure, removal, or encapsulation of greater than ten but less than 260 linear feet of friable asbestos-containing material on pipes, greater than six but less than 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, greater than one cubic foot but less than 35 cubic feet of friable asbestos-containing material on or off all facility components in one facility. ~~This provision excludes asbestos-containing floor tiles and sheeting, roofing materials, siding, and all ceilings with asbestos-containing material in single family residences and buildings with no more than four dwelling units.~~ Asbestos-related work includes asbestos abatement area preparation; enclosure, removal, or encapsulation operations; and an air quality monitoring specified in rule to assure that the abatement and adjacent areas are not contaminated with asbestos fibers during the project and after completion.

For purposes of this subdivision, the quantity of ~~asbestos-containing~~ material applies 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.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2022	**2023**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	**$ 4,232,594,000**	**$ 4,385,195,000**

Appropriations by Fund

	2022	2023
General	3,361,282,000	3,535,836,000
State Government Special Revenue	4,174,000	4,174,000
Health Care Access	867,038,000	845,085,000
Federal TANF	100,000	100,000

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

Subd. 2. **Information Technology**

(a) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(b) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must 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**

	Appropriations by Fund	
123.16 General	157,188,000	161,099,000
123.17 State Government 123.18 Special Revenue	4,174,000	4,174,000
123.19 Health Care Access	20,709,000	20,709,000
123.20 Federal TANF	100,000	100,000

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	Appropriations by Fund		
124.10	General	21,942,000	22,360,000
124.11	Health Care Access	24,313,000	24,313,000

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	Appropriations by Fund		
124.30	General	30,000	-0-

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.

(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.

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.