

ARTICLE 9**ONECARE**

Section 1. Minnesota Statutes 2018, section 62J.497, subdivision 1, is amended to read:

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

(b) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(d) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(e) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(f) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(g) "Electronic prescription drug program" means a program that provides for e-prescribing.

(h) "Group purchaser" has the meaning given in section 62J.03, subdivision 6, excluding state and federal health care programs under chapters 256B, 256L, and 256T.

(i) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(j) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(k) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(l) "NCPDP Formulary and Benefits Standard" means the National Council for Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0, October 2005.

580.4 (m) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug
 580.5 Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version
 580.6 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by the Centers
 580.7 for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required
 580.8 by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it.
 580.9 The standards shall be implemented according to the Centers for Medicare and Medicaid
 580.10 Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT
 580.11 Standard may be used, provided that the new version of the standard is backward compatible
 580.12 to the current version adopted by the Centers for Medicare and Medicaid Services.

580.13 (n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

580.14 (o) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as
 580.15 defined in section 151.01, subdivision 23.

580.16 (p) "Prescription-related information" means information regarding eligibility for drug
 580.17 benefits, medication history, or related health or drug information.

580.18 (q) "Provider" or "health care provider" has the meaning given in section 62J.03,
 580.19 subdivision 8.

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

580.21 Sec. 2. [62V.12] ADVANCED PAYMENT OF STATE-BASED HEALTH
 580.22 INSURANCE PREMIUM TAX CREDIT.

580.23 Subdivision 1. **Determination of eligibility for advanced payment of state-based**
 580.24 **health insurance premium tax credit.** (a) The Board of Directors of MNsure shall assess
 580.25 an individual's eligibility for an advanced payment of the state-based health insurance tax
 580.26 credit under section 290.0693 when an individual applies for an eligibility determination
 580.27 through MNsure, basing the eligibility determination upon income for the relevant tax year
 580.28 as projected by the individual. MNsure shall equally divide the value of the potential
 580.29 state-based tax credit across the monthly premiums to be charged to the individual. If the
 580.30 individual selects a plan through MNsure, MNsure shall notify the relevant health carrier
 580.31 of the amount of the advanced payment of the state-based insurance premium tax credit
 580.32 amount and direct the health carrier to deduct the amount from the eligible individual's
 580.33 premiums.

581.1 (b) An individual is eligible for an advanced payment of the state-based health insurance
 581.2 premium tax credit if they are a Minnesota resident who:

581.3 (1) had at least one month of coverage by a qualified health plan offered through MNsure
 581.4 during the tax year;

581.5 (2) was not enrolled in public program coverage under section 256B.055 or 256L.04
 581.6 during the months of coverage by the qualified health plan; and

- 581.7 (3) is eligible for the health insurance tax credit in section 290.0693.
- 581.8 (c) To be eligible for an advanced payment of the state-based health insurance premium
- 581.9 tax credit, the individual must attest that the individual will file a state tax return in order
- 581.10 to reconcile any advanced payment of the credit and will file a joint tax return with their
- 581.11 spouse, if married.
- 581.12 (d) An individual is not eligible for an advanced payment of the state-based health
- 581.13 insurance premium tax credit for the taxable year if MNsure is notified by the commissioner
- 581.14 of revenue that the individual received an advanced payment in a prior tax year and has not
- 581.15 filed a tax return for the relevant tax year and has not fully paid any amount necessary to
- 581.16 reconcile the advanced payment.
- 581.17 Subd. 2. **Payments to health carriers.** The board shall make payments to health carriers
- 581.18 equal to the amount of the advance state-based health insurance premium tax credit amounts
- 581.19 provided to eligible individuals effectuating coverage for the months in which the individual
- 581.20 has paid the net premium amount to the health carrier.
- 581.21 Subd. 3. **Health carrier responsibilities.** A health carrier that receives notice from
- 581.22 MNsure that an individual enrolled in the health carrier's qualified health plan is eligible
- 581.23 for an advanced payment of the state-based health insurance premium tax credit shall:
- 581.24 (1) reduce the portion of the premium charged to the individual for the applicable months
- 581.25 by the amount of the state-based health insurance tax credit determined by MNsure;
- 581.26 (2) include the amount of advanced state-based health insurance premium tax credit
- 581.27 determined by MNsure on each billing statement for which an advanced state-based health
- 581.28 insurance tax credit has been applied; and
- 581.29 (3) reconcile advanced payments of state-based health insurance premium tax credits
- 581.30 with MNsure at least once a month.
- 581.31 Subd. 4. **Appeals.** MNsure appeals are available for Minnesota residents for initial
- 581.32 determinations and redeterminations made by MNsure of eligibility for and level of an
- 582.1 advanced payment of the state-based health insurance premium tax credit. The appeals must
- 582.2 follow the procedures enumerated in Minnesota Rules, chapter 7700.
- 582.3 Subd. 5. **Data practices.** The data classifications in section 62V.06, subdivision 3, apply
- 582.4 to data on individuals applying for or receiving a state-based health insurance tax credit
- 582.5 pursuant to this subdivision.
- 582.6 Subd. 6. **Data sharing.** Notwithstanding any law to the contrary, the board is permitted
- 582.7 to share or disseminate data in subdivision 5 as described in section 62V.06, subdivision 5.
- 582.8 Subd. 7. **Appropriations.** Beginning in fiscal year 2021 and each fiscal year thereafter,
- 582.9 an amount sufficient to make advanced payments of the state-based health insurance tax

582.10 credit is appropriated from the health care access fund to the board for payment of advanced
582.11 state-based health insurance premium tax credits under this section.

582.12 **EFFECTIVE DATE.** This section is effective for advanced payment of the state-based
582.13 health insurance premium tax credit applied to premiums for plan years 2021 and beyond.

582.14 Sec. 3. **[62V.13] DEFINITIONS.**

582.15 Subdivision 1. **Scope.** For purposes of sections 62V.13 to 62V.133, the following terms
582.16 have the meanings given.

582.17 Subd. 2. **Board.** "Board" means the board of directors of MNsure specified in section
582.18 62V.04.

582.19 Subd. 3. **Eligible individual.** "Eligible individual" means a Minnesota resident who:

582.20 (1) is determined not eligible to receive an advance credit payment under Code of Federal
582.21 Regulations, title 26, section 1.36B-1(j), of the premium tax credit under Code of Federal
582.22 Regulations, title 26, section 1.36B-2, for a given month of coverage;

582.23 (2) is not enrolled in public program coverage under section 256B.055 or 256L.04; and

582.24 (3) purchased a qualified health plan through MNsure.

582.25 Subd. 4. **Gross premium.** "Gross premium" means the amount billed for a qualified
582.26 health plan purchased by an eligible individual prior to a premium subsidy or advanced
582.27 state-based tax credit being applied in a calendar year.

582.28 Subd. 5. **Health carrier.** "Health carrier" has the meaning given in section 62A.011,
582.29 subdivision 2.

583.1 Subd. 6. **MNsure.** "MNsure" means the state health benefit exchange as described in
583.2 section 1311 of the federal Patient Protection and Affordable Care Act, Public Law 111-148,
583.3 and chapter 62V.

583.4 Subd. 7. **Net premium.** "Net premium" means the gross premium less the premium
583.5 subsidy.

583.6 Subd. 8. **Premium subsidy.** "Premium subsidy":

583.7 (1) is a rebate payment to discount the cost of insurance for the promotion of general
583.8 welfare, and is not compensation for any services;

583.9 (2) is equal to 20 percent of the monthly gross premium otherwise paid by or on behalf
583.10 of the eligible individual for qualified health plan coverage purchased through MNsure that
583.11 covers the eligible individual and the eligible individual's covered spouse and covered
583.12 dependents; and

583.13 (3) is excluded from any calculation used to determine eligibility within any of the
583.14 Department of Human Services programs.

583.15 Subd. 9. **Qualified health plan.** "Qualified health plan" means a health plan that meets
583.16 the definition in section 1301(a) of the Affordable Care Act, Public Law 111-148, and has
583.17 been certified by the board in accordance with section 62V.05, subdivision 5, to be offered
583.18 through MNsure.

583.19 Sec. 4. **[62V.131] PAYMENT TO HEALTH CARRIERS ON BEHALF OF ELIGIBLE**
583.20 **INDIVIDUALS.**

583.21 Subdivision 1. **Program established.** The board shall establish and administer the
583.22 premium subsidy program authorized by this act to help eligible individuals pay for coverage
583.23 when purchasing qualified health plans through MNsure in plan year 2020 and in each
583.24 subsequent plan year for which an appropriation is approved.

583.25 Subd. 2. **Administration.** MNsure shall determine if an individual applying for coverage
583.26 through MNsure is an eligible individual. If so, MNsure shall calculate the proper amount
583.27 of the eligible individual's premium subsidy. MNsure shall notify the relevant health carrier
583.28 of the premium subsidy amount and direct the health carrier to deduct the premium subsidy
583.29 amount from the eligible individual's gross premium as a discount to the eligible individual's
583.30 qualified health plan premium.

583.31 Subd. 3. **Payments to health carriers.** (a) The board shall make payments to health
583.32 carriers equal to the amount of the premium subsidy discounts provided to eligible individuals
584.1 effectuating coverage for the months in which the individual has paid the net premium
584.2 amount to the health carrier. Payments to health carriers shall be based on the premium
584.3 subsidy provided on behalf of eligible individuals, regardless of the cost of coverage
584.4 purchased.

584.5 (b) Health carriers seeking reimbursement from the board must submit an invoice and
584.6 supporting information to the board using a format and method developed by the board in
584.7 order to be determined to be eligible for payment.

584.8 (c) The board shall consider health carriers as vendors under section 16A.124, subdivision
584.9 3, and each monthly invoice shall represent the completed delivery of the service.

584.10 Subd. 4. **Data practices.** The data classifications in section 62V.06, subdivision 3, apply
584.11 to data on individuals applying for or receiving a premium subsidy under this subdivision.

584.12 Subd. 5. **Data sharing.** Notwithstanding any law to the contrary, the board is permitted
584.13 to share or disseminate the data in subdivision 4 as described in section 62V.06, subdivision
584.14 5.

584.15 Sec. 5. **[62V.132] APPEALS.**

- 584.16 MNsure appeals are available for Minnesota residents for initial determinations and
584.17 redeterminations made by MNsure of eligibility for and level of premium subsidy and shall
584.18 follow the procedures enumerated in Minnesota Rules, chapter 7700.
- 584.19 Sec. 6. [62V.133] APPLICABILITY OF GROSS PREMIUM.
- 584.20 Notwithstanding premium subsidies provided under section 62V.131, the premium base
584.21 for calculating the amount of any applicable premium taxes under chapter 297I, shall be
584.22 the gross premium for a qualified health plan purchased by eligible individuals through
584.23 MNsure.
- 584.24 Sec. 7. [256B.0371] ADMINISTRATION OF DENTAL SERVICES.
- 584.25 (a) Effective January 1, 2022, the commissioner shall contract with a dental administrator
584.26 to administer dental services for all recipients of medical assistance and MinnesotaCare.
- 584.27 (b) The dental administrator must provide administrative services including but not
584.28 limited to:
- 584.29 (1) provider recruitment, contracting, and assistance;
- 584.30 (2) recipient outreach and assistance;
- 585.1 (3) utilization management and review for medical necessity of dental services;
- 585.2 (4) dental claims processing;
- 585.3 (5) coordination with other services;
- 585.4 (6) management of fraud and abuse;
- 585.5 (7) monitoring of access to dental services;
- 585.6 (8) performance measurement;
- 585.7 (9) quality improvement and evaluation requirements; and
- 585.8 (10) management of third-party liability requirements.
- 585.9 (c) Payments to contracted dental providers must be at the rates established under section
585.10 256B.76.
- 585.11 **EFFECTIVE DATE.** This section is effective January 1, 2022.
- 585.12 Sec. 8. Minnesota Statutes 2018, section 256B.0644, is amended to read:
- 585.13 256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE
- 585.14 PROGRAMS.
- 585.15 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health
585.16 maintenance organization, as defined in chapter 62D, must participate as a provider or
585.17 contractor in the medical assistance program and MinnesotaCare as a condition of

585.18 participating as a provider in health insurance plans and programs or contractor for state
585.19 employees established under section 43A.18, the public employees insurance program under
585.20 section 43A.316, for health insurance plans offered to local statutory or home rule charter
585.21 city, county, and school district employees, the workers' compensation system under section
585.22 176.135, and insurance plans provided through the Minnesota Comprehensive Health
585.23 Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to
585.24 local government employees shall not be applicable in geographic areas where provider
585.25 participation is limited by managed care contracts with the Department of Human Services.
585.26 This section does not apply to dental service providers providing dental services outside
585.27 the seven-county metropolitan area.

585.28 (b) For providers other than health maintenance organizations, participation in the medical
585.29 assistance program means that:

585.30 (1) the provider accepts new medical assistance and MinnesotaCare patients;

586.1 (2) for providers other than dental service providers, at least 20 percent of the provider's
586.2 patients are covered by medical assistance and MinnesotaCare as their primary source of
586.3 coverage; or

586.4 (3) for dental service providers providing dental services in the seven-county metropolitan
586.5 area, at least ten percent of the provider's patients are covered by medical assistance and
586.6 MinnesotaCare as their primary source of coverage, or the provider accepts new medical
586.7 assistance and MinnesotaCare patients who are children with special health care needs. For
586.8 purposes of this section, "children with special health care needs" means children up to age
586.9 18 who: (i) require health and related services beyond that required by children generally;
586.10 and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional
586.11 condition, including: bleeding and coagulation disorders; immunodeficiency disorders;
586.12 cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other
586.13 neurological diseases; visual impairment or deafness; Down syndrome and other genetic
586.14 disorders; autism; fetal alcohol syndrome; and other conditions designated by the
586.15 commissioner after consultation with representatives of pediatric dental providers and
586.16 consumers.

586.17 (c) Patients seen on a volunteer basis by the provider at a location other than the provider's
586.18 usual place of practice may be considered in meeting the participation requirement in this
586.19 section. The commissioner shall establish participation requirements for health maintenance
586.20 organizations. The commissioner shall provide lists of participating medical assistance
586.21 providers on a quarterly basis to the commissioner of management and budget, the
586.22 commissioner of labor and industry, and the commissioner of commerce. Each of the
586.23 commissioners shall develop and implement procedures to exclude as participating providers
586.24 in the program or programs under their jurisdiction those providers who do not participate
586.25 in the medical assistance program. The commissioner of management and budget shall
586.26 implement this section through contracts with participating health and dental carriers.

586.27 (d) A volunteer dentist who has signed a volunteer agreement under section 256B.0625,
586.28 subdivision 9a, shall not be considered to be participating in medical assistance or
586.29 MinnesotaCare for the purpose of this section.

586.30 (e) A vendor of medical care, as defined in section 256B.02, subdivision 7, that dispenses
586.31 outpatient prescription drugs in accordance with chapter 151 must participate as a provider
586.32 or contractor in the MinnesotaCare program as a condition of participating as a provider in
586.33 the medical assistance program.

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

587.1 Sec. 9. Minnesota Statutes 2018, section 256B.69, subdivision 6d, is amended to read:

587.2 Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude ~~or modify~~ coverage
587.3 for prescription drugs from the prepaid managed care contracts entered into under this
587.4 section ~~in order to increase savings to the state by collecting additional prescription drug~~
587.5 ~~rebates. The contracts must maintain incentives for the managed care plan to manage drug~~
587.6 ~~costs and utilization and may require that the managed care plans maintain an open drug~~
587.7 ~~formulary. In order to manage drug costs and utilization, the contracts may authorize the~~
587.8 ~~managed care plans to use preferred drug lists and prior authorization. This subdivision is~~
587.9 ~~contingent on federal approval of the managed care contract changes and the collection of~~
587.10 ~~additional prescription drug rebates.~~

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

587.12 Sec. 10. Minnesota Statutes 2018, section 256B.69, subdivision 35, is amended to read:

587.13 Subd. 35. **Statewide procurement.** (a) For calendar year 2015, the commissioner may
587.14 extend a demonstration provider's contract under this section for a sixth year after the most
587.15 recent procurement. For calendar year 2015, section 16B.98, subdivision 5, paragraph (b),
587.16 and section 16C.05, subdivision 2, paragraph (b), shall not apply to contracts under this
587.17 section.

587.18 (b) For calendar year 2016 contracts under this section, the commissioner shall procure
587.19 through a statewide procurement, which includes all 87 counties, demonstration providers,
587.20 and participating entities as defined in section 256L.01, subdivision 7. The commissioner
587.21 shall publish a request for proposals by January 5, 2015. As part of the procurement process,
587.22 the commissioner shall:

587.23 (1) seek each individual county's input;

587.24 (2) organize counties into regional groups, and consider single counties for the largest
587.25 and most diverse counties; and

587.26 (3) seek regional and county input regarding the respondent's ability to fully and
587.27 adequately deliver required health care services, offer an adequate provider network, provide
587.28 care coordination with county services, and serve special populations, including enrollees
587.29 with language and cultural needs.

587.30 (c) For calendar year 2021, the commissioner may extend a demonstration provider's
587.31 contract under this section for a sixth year after the most recent procurement, for the provision
587.32 of services in the seven-county metropolitan area to families and children under medical
587.33 assistance and MinnesotaCare. For calendar year 2021, sections 16B.98, subdivision 5,
588.1 paragraph (b), and 16C.06, subdivision 3b, shall not apply to contracts under this section.
588.2 For calendar year 2022, the commissioner shall procure services in the seven-county
588.3 metropolitan area for families and children under medical assistance and MinnesotaCare,
588.4 from demonstration providers and participating entities as defined in section 256L.01,
588.5 subdivision 7.

588.6 Sec. 11. Minnesota Statutes 2018, section 256B.76, subdivision 2, is amended to read:

588.7 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October
588.8 1, 1992, the commissioner shall make payments for dental services as follows:

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

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

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

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

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

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

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

588.27 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in
588.28 paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal year, a
588.29 supplemental state payment equal to the difference between the total payments in paragraph
588.30 (f) and \$1,850,000 shall be paid from the general fund to state-operated services for the
588.31 operation of the dental clinics.

589.1 (h) If the cost-based payment system for state-operated dental clinics described in
589.2 paragraph (f) does not receive federal approval, then state-operated dental clinics shall be

589.3 designated as critical access dental providers under subdivision 4, paragraph (b), and shall
589.4 receive the critical access dental reimbursement rate as described under subdivision 4,
589.5 paragraph (a).

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

589.9 (j) Effective for services rendered on or after January 1, 2014, payment rates for dental
589.10 services shall be increased by five percent from the rates in effect on December 31, 2013.
589.11 This increase does not apply to state-operated dental clinics in paragraph (f), federally
589.12 qualified health centers, rural health centers, and Indian health services. Effective January
589.13 1, 2014, payments made to managed care plans and county-based purchasing plans under
589.14 sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in
589.15 this paragraph.

589.16 (k) Effective for services rendered on or after July 1, 2015, through December 31, 2016,
589.17 the commissioner shall increase payment rates for services furnished by dental providers
589.18 located outside of the seven-county metropolitan area by the maximum percentage possible
589.19 above the rates in effect on June 30, 2015, while remaining within the limits of funding
589.20 appropriated for this purpose. This increase does not apply to state-operated dental clinics
589.21 in paragraph (f), federally qualified health centers, rural health centers, and Indian health
589.22 services. Effective January 1, 2016, through December 31, 2016, payments to managed care
589.23 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect
589.24 the payment increase described in this paragraph. The commissioner shall require managed
589.25 care and county-based purchasing plans to pass on the full amount of the increase, in the
589.26 form of higher payment rates to dental providers located outside of the seven-county
589.27 metropolitan area.

589.28 (l) Effective for services provided on or after January 1, 2017, through December 31,
589.29 2021, the commissioner shall increase payment rates by 9.65 percent for dental services
589.30 provided outside of the seven-county metropolitan area. This increase does not apply to
589.31 state-operated dental clinics in paragraph (f), federally qualified health centers, rural health
589.32 centers, or Indian health services. Effective January 1, 2017, payments to managed care
589.33 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect
589.34 the payment increase described in this paragraph.

590.1 (m) Effective for services provided on or after July 1, 2017, through December 31, 2021,
590.2 the commissioner shall increase payment rates by 23.8 percent for dental services provided
590.3 to enrollees under the age of 21. This rate increase does not apply to state-operated dental
590.4 clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian
590.5 health centers. This rate increase does not apply to managed care plans and county-based
590.6 purchasing plans.

590.7 (n) Effective for dental services provided on or after January 1, 2022, the commissioner
590.8 shall increase payment rates by 54 percent. This rate increase does not apply to state-operated

590.9 dental clinics in paragraph (f), federally qualified health centers, rural health centers, or
590.10 Indian health centers.

590.11 Sec. 12. Minnesota Statutes 2018, section 256B.76, subdivision 4, is amended to read:

590.12 Subd. 4. **Critical access dental providers.** (a) The commissioner shall increase
590.13 reimbursements to dentists and dental clinics deemed by the commissioner to be critical
590.14 access dental providers. For dental services rendered on or after July 1, 2016, through
590.15 December 31, 2021, the commissioner shall increase reimbursement by 37.5 percent above
590.16 the reimbursement rate that would otherwise be paid to the critical access dental provider,
590.17 except as specified under paragraph (b). The commissioner shall pay the managed care
590.18 plans and county-based purchasing plans in amounts sufficient to reflect increased
590.19 reimbursements to critical access dental providers as approved by the commissioner.

590.20 (b) For dental services rendered on or after July 1, 2016, by a dental clinic or dental
590.21 group that meets the critical access dental provider designation under paragraph (d), clause
590.22 (4), and is owned and operated by a health maintenance organization licensed under chapter
590.23 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement
590.24 rate that would otherwise be paid to the critical access provider.

590.25 (c) Critical access dental payments made under paragraph (a) or (b) for dental services
590.26 provided by a critical access dental provider to an enrollee of a managed care plan or
590.27 county-based purchasing plan must not reflect any capitated payments or cost-based payments
590.28 from the managed care plan or county-based purchasing plan. The managed care plan or
590.29 county-based purchasing plan must base the additional critical access dental payment on
590.30 the amount that would have been paid for that service had the dental provider been paid
590.31 according to the managed care plan or county-based purchasing plan's fee schedule that
590.32 applies to dental providers that are not paid under a capitated payment or cost-based payment.

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

591.1 (1) nonprofit community clinics that:

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

591.3 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
591.4 501(c)(3);

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

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

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

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

591.12 (vii) have free care available as needed;

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

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

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

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

591.21 (6) private practicing dentists if:

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

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

592.1 Sec. 13. Minnesota Statutes 2018, section 256L.03, is amended by adding a subdivision
 592.2 to read:

592.3 Subd. 7. **Outpatient prescription drugs.** Outpatient prescription drugs are covered
 592.4 according to section 256L.30. This subdivision applies to all individuals enrolled in the
 592.5 MinnesotaCare program.

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

592.7 Sec. 14. Minnesota Statutes 2018, section 256L.07, subdivision 2, is amended to read:

592.8 Subd. 2. **Must not have access to employer-subsidized minimum essential**
 592.9 **coverage.** (a) To be eligible, a family or individual must not have access to subsidized health
 592.10 coverage that is affordable and provides minimum value as defined in Code of Federal
 592.11 Regulations, title 26, section 1.36B-2.

592.12 (b) Notwithstanding paragraph (a), an individual who has access to subsidized health
 592.13 coverage through a spouse's or parent's employer that is deemed minimum essential coverage
 592.14 under Code of Federal Regulations, title 26, section 1.36B-2, is eligible for MinnesotaCare
 592.15 if the portion of the annual premium the employee pays for employee and dependent coverage
 592.16 exceeds the required contribution percentage as described in Code of Federal Regulations,

592.17 title 26, section 1.36B-2, and the individual meets all other eligibility requirements of this
592.18 chapter.

592.19 ~~(b)~~ (c) This subdivision does not apply to a family or individual who no longer has
592.20 employer-subsidized coverage due to the employer terminating health care coverage as an
592.21 employee benefit.

592.22 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
592.23 whichever is later. The commissioner of human services shall notify the revisor of statutes
592.24 when federal approval is obtained.

592.25 Sec. 15. Minnesota Statutes 2018, section 256L.07, is amended by adding a subdivision
592.26 to read:

592.27 Subd. 2b. **Federal waiver.** The commissioner of human services, in consultation with
592.28 the Board of Directors of MNsure, shall apply for a federal waiver to allow the state to
592.29 permit a person who has access to employer-sponsored health insurance through a spouse
592.30 or parent that is deemed minimum essential coverage under Code of Federal Regulations,
592.31 title 26, section 1.36B-2, and the portion of the annual premium the person pays for employee
593.1 and dependent coverage exceeds the required contribution percentage in Code of Federal
593.2 Regulations, title 26, section 1.36B-2, to:

593.3 (1) enroll in the MinnesotaCare program, if the person meets all eligibility requirements,
593.4 except for section 256L.07, subdivision 2, paragraph (a);

593.5 (2) qualify for advanced premium tax credits under Code of Federal Regulations, title
593.6 26, section 1.36B-2, and cost sharing reductions under Code of Federal Regulations, title
593.7 45, section 155.305(g), if the person meets all eligibility requirements, except for the
593.8 affordability requirement described in Code of Federal Regulations, title 26, section 1.36B-2
593.9 (c)(3)(v)(A)(2); and

593.10 (3) qualify to purchase coverage in the OneCare Buy-In pursuant to section 256T.03, if
593.11 the person meets all eligibility requirements.

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

593.13 Sec. 16. Minnesota Statutes 2018, section 256L.11, subdivision 7, is amended to read:

593.14 Subd. 7. **Critical access dental providers.** Effective for dental services provided to
593.15 MinnesotaCare enrollees on or after July 1, 2017, through December 31, 2021, the
593.16 commissioner shall increase payment rates to dentists and dental clinics deemed by the
593.17 commissioner to be critical access providers under section 256B.76, subdivision 4, by 20
593.18 percent above the payment rate that would otherwise be paid to the provider. The
593.19 commissioner shall pay the prepaid health plans under contract with the commissioner
593.20 amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate
593.21 increase to providers who have been identified by the commissioner as critical access dental
593.22 providers under section 256B.76, subdivision 4.

593.23 Sec. 17. [256L.30] OUTPATIENT PRESCRIPTION DRUGS.

593.24 Subdivision 1. **Establishment of program.** The commissioner shall administer and
593.25 oversee the outpatient prescription drug program for MinnesotaCare. The commissioner
593.26 shall not include the outpatient pharmacy benefit in a contract with a public or private entity.

593.27 Subd. 2. **Covered outpatient prescription drugs.** (a) In consultation with the Drug
593.28 Formulary Committee under section 256B.0625, subdivision 13d, the commissioner shall
593.29 establish an outpatient prescription drug formulary for MinnesotaCare that satisfies the
593.30 requirements for an essential health benefit under Code of Federal Regulations, title 45,
593.31 section 156.122. The commissioner may modify the formulary after consulting with the
593.32 Drug Formulary Committee and providing public notice and the opportunity for public
594.1 comment. The commissioner is exempt from the rulemaking requirements of chapter 14 to
594.2 establish the drug formulary, and section 14.386 does not apply. The commissioner shall
594.3 make the drug formulary available to the public on the agency website.

594.4 (b) The MinnesotaCare formulary must contain at least one drug in every United States
594.5 Pharmacopeia category and class or the same number of prescription drugs in each category
594.6 and class as the essential health benefit benchmark plan, whichever is greater.

594.7 (c) The commissioner may negotiate drug rebates or discounts directly with a drug
594.8 manufacturer to place a drug on the formulary. The commissioner may also negotiate drug
594.9 rebates, or discounts, with a drug manufacturer through a contract with a vendor. The
594.10 commissioner, beginning January 15, 2022, and each January 15 thereafter, shall notify the
594.11 chairs and ranking minority members of the legislative committees with jurisdiction over
594.12 health and human services policy and finance of the rebates and discounts negotiated, their
594.13 aggregate dollar value, and how the department applied these savings, including the extent
594.14 to which these savings were passed on to enrollees.

594.15 (d) Prior authorization may be required by the commissioner before certain formulary
594.16 drugs are eligible for payment. The Drug Formulary Committee may recommend drugs for
594.17 prior authorization directly to the commissioner. The commissioner may also request that
594.18 the Drug Formulary Committee review a drug for prior authorization.

594.19 (e) Before the commissioner requires prior authorization for a drug:

594.20 (1) the commissioner must provide the Drug Formulary Committee with information
594.21 on the impact that placing the drug on prior authorization may have on the quality of patient
594.22 care and on program costs and information regarding whether the drug is subject to clinical
594.23 abuse or misuse if such data is available; and

594.24 (2) the Drug Formulary Committee must hold a public forum and receive public comment
594.25 for an additional 15 days from the date of the public forum.

594.26 (f) Notwithstanding paragraph (e), the commissioner may automatically require prior
594.27 authorization for a period not to exceed 180 days for any drug that is approved by the United
594.28 States Food and Drug Administration after July 1, 2019. The 180-day period begins no later

594.29 than the first day that a drug is available for shipment to pharmacies within the state. The
594.30 Drug Formulary Committee shall recommend to the commissioner general criteria to use
594.31 for determining prior authorization of the drugs, but the Drug Formulary Committee is not
594.32 required to review each individual drug.

595.1 (g) The commissioner may also require prior authorization before nonformulary drugs
595.2 are eligible for payment.

595.3 (h) Prior authorization requests must be processed in accordance with Code of Federal
595.4 Regulations, title 45, section 156.122.

595.5 Subd. 3. **Pharmacy provider participation.** (a) A pharmacy enrolled to dispense
595.6 prescription drugs to medical assistance enrollees under section 256B.0625 must participate
595.7 as a provider in the MinnesotaCare outpatient prescription drug program.

595.8 (b) A pharmacy that is enrolled to dispense prescription drugs to MinnesotaCare enrollees
595.9 is not permitted to refuse service to an enrollee unless:

595.10 (1) the pharmacy does not have a prescription drug in stock and cannot obtain the drug
595.11 in time to treat the enrollee's medical condition;

595.12 (2) the enrollee is unable or unwilling to pay the enrollee's co-payment at the time the
595.13 drug is dispensed;

595.14 (3) after performing drug utilization review, the pharmacist identifies the prescription
595.15 drug as being a therapeutic duplication, having a drug-disease contraindication, having a
595.16 drug-drug interaction, having been prescribed for the incorrect dosage or duration of
595.17 treatment, having a drug-allergy interaction, or having issues related to clinical abuse or
595.18 misuse by the enrollee;

595.19 (4) the prescription drug is not covered by MinnesotaCare; or

595.20 (5) dispensing the drug would violate a provision of chapter 151.

595.21 Subd. 4. **Covered outpatient prescription drug reimbursement rate.** (a) The basis
595.22 for determining the amount of payment shall be the lowest of the National Average Drug
595.23 Acquisition Cost, plus a fixed dispensing fee; the maximum allowable cost established
595.24 under section 256B.0625, subdivision 13e, plus a fixed dispensing fee; or the usual and
595.25 customary price. The fixed dispensing fee shall be \$1.50 for covered outpatient prescription
595.26 drugs.

595.27 (b) The basis for determining the amount of payment for a pharmacy that acquires drugs
595.28 through the federal 340B Drug Pricing Program shall be the lowest of:

595.29 (1) the National Average Drug Acquisition Cost minus 30 percent;

595.30 (2) the maximum allowable cost established under section 256B.0625, subdivision 13e,
595.31 minus 30 percent, plus a fixed dispensing fee; or

596.1 (3) the usual and customary price. The fixed dispensing fee shall be \$1.50 for covered
596.2 outpatient prescription drugs.

596.3 (c) For purposes of this subdivision, the usual and customary price is the lowest price
596.4 charged by the provider to a patient who pays for the prescription by cash, check, or charge
596.5 account and includes the prices the pharmacy charges to customers enrolled in a prescription
596.6 savings club or prescription discount club administered by the pharmacy, pharmacy chain,
596.7 or contractor to the provider.

596.8 Subd. 5. **Prescription drug benefit consumer protections.** The prescription drug benefit
596.9 shall include the protections required under Code of Federal Regulations, title 45, section
596.10 156.122, including a standard formulary exception request, expedited exception request,
596.11 external exception request, and application of coverage appeals laws.

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

596.13 Sec. 18. [256T.01] DEFINITIONS.

596.14 Subdivision 1. **Application.** For purposes of this chapter, the terms in this section have
596.15 the meanings given.

596.16 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

596.17 Subd. 3. **Department.** "Department" means the Department of Human Services.

596.18 Subd. 4. **Essential health benefits.** "Essential health benefits" has the meaning given
596.19 in section 62Q.81, subdivision 4.

596.20 Subd. 5. **Health plan.** "Health plan" has the meaning given in section 62A.011,
596.21 subdivision 3.

596.22 Subd. 6. **Individual market.** "Individual market" has the meaning given in section
596.23 62A.011, subdivision 5.

596.24 Subd. 7. **MNsure website.** "MNsure website" has the meaning given in section 62V.02,
596.25 subdivision 13.

596.26 Subd. 8. **Qualified health plan.** "Qualified health plan" has the meaning given in section
596.27 62A.011, subdivision 7.

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

597.1 Sec. 19. [256T.02] ONECARE BUY-IN.

597.2 Subdivision 1. **Establishment.** (a) The commissioner shall establish a program consistent
597.3 with this section to offer products developed for the OneCare Buy-In through the MNsure
597.4 website.

597.5 (b) The commissioner, in collaboration with the commissioner of commerce and the
 597.6 MNsure Board, shall:

597.7 (1) establish a cost allocation methodology to reimburse MNsure operations in lieu of
 597.8 the premium withhold for qualified health plans under section 62V.05;

597.9 (2) implement mechanisms to ensure the long-term financial sustainability of Minnesota's
 597.10 public health care programs and mitigate any adverse financial impacts to the state and
 597.11 MNsure. These mechanisms must minimize adverse selection, state financial risk and
 597.12 contribution, and negative impacts to premiums in the individual and group health insurance
 597.13 markets; and

597.14 (3) coordinate eligibility, coverage, and provider networks to ensure that persons, to the
 597.15 extent possible, transitioning between medical assistance, MinnesotaCare, and the OneCare
 597.16 Buy-In have continuity of care.

597.17 (c) The OneCare Buy-In shall be considered:

597.18 (1) a public health care program for purposes of chapter 62V; and

597.19 (2) the MinnesotaCare program for purposes of requirements for health maintenance
 597.20 organizations under section 62D.04, subdivision 5, and providers under section 256B.0644.

597.21 (d) The Department of Human Services is deemed to meet and receive certification and
 597.22 authority under section 62D.03 and be in compliance with sections 62D.01 to 62D.30. The
 597.23 commissioner has the authority to accept and expend all federal funds made available under
 597.24 this chapter upon federal approval.

597.25 (e) Unless otherwise specified under this chapter, health plans offered under the OneCare
 597.26 Buy-In program must meet all requirements of chapters 62A, 62D, 62K, 62M, 62Q, and
 597.27 62V determined to be applicable by the regulating authority and premiums shall be subject
 597.28 to the gross premiums tax under section 2971.05, subdivision 5.

597.29 Subd. 2. **Premium administration and payment.** (a) The commissioner shall establish
 597.30 annually a per-enrollee monthly premium rate.

598.1 (b) OneCare Buy-In premium administration shall be consistent with requirements under
 598.2 the federal Affordable Care Act for qualified health plan premium administration. Premium
 598.3 rates shall be established in accordance with section 62A.65, subdivision 3.

598.4 Subd. 3. **Rates to providers.** The commissioner shall establish rates for provider
 598.5 payments that are targeted to the current rates established under chapter 256L, plus the
 598.6 aggregate difference between those rates and Medicare rates. The aggregate must not consider
 598.7 services that receive a Medicare encounter payment.

598.8 Subd. 4. **Reserve and other financial requirements.** (a) A OneCare Buy-In reserve
 598.9 account is established in the state treasury. Enrollee premiums collected under subdivision
 598.10 2 shall be deposited into the reserve account. The reserve account shall be used to cover

598.11 expenditures related to operation of the OneCare Buy-In, including the payment of claims
598.12 and all other accrued liabilities. No other account within the state treasury shall be used to
598.13 finance the reserve account except as otherwise specified in state law.

598.14 (b) Beginning January 1, 2023, enrollee premiums shall be set at a level sufficient to
598.15 fund all ongoing claims costs and all ongoing costs necessary to manage the program and
598.16 support ongoing maintenance of information technology systems and operational and
598.17 administrative functions of the OneCare Buy-In program.

598.18 (c) The commissioner is prohibited from expending state dollars beyond what is
598.19 specifically appropriated in law, or transferring funds from other accounts, in order to fund
598.20 the reserve account, fund claims costs, or support ongoing administration and operation of
598.21 the program and its information technology systems.

598.22 Subd. 5. **Covered benefits.** Each health plan established under this chapter must include
598.23 the essential health benefits package required under section 1302(a) of the Affordable Care
598.24 Act and as described in section 62Q.81; dental services described in section 256B.0625,
598.25 subdivision 9, paragraphs (b) and (c); and vision services described in Minnesota Rules,
598.26 part 9505.0277, and may include other services under section 256L.03, subdivision 1.

598.27 Subd. 6. **Third-party administrator.** (a) The commissioner may enter into a contract
598.28 with a third-party administrator to perform the operational management of the OneCare
598.29 Buy-In. Duties of the third-party administrator include but are not limited to the following:

598.30 (1) development and distribution of plan materials for potential enrollees;

598.31 (2) receipt and processing of electronic enrollment files sent from the state;

599.1 (3) creation and distribution of plan enrollee materials including identification cards,
599.2 certificates of coverage, a plan formulary, a provider directory, and premium billing
599.3 statements;

599.4 (4) processing premium payments and sending termination notices for nonpayment to
599.5 enrollees and the state;

599.6 (5) payment and adjudication of claims;

599.7 (6) utilization management;

599.8 (7) coordination of benefits;

599.9 (8) grievance and appeals activities; and

599.10 (9) fraud, waste, and abuse prevention activities.

599.11 (b) Any solicitation of vendors to serve as the third-party administrator is subject to the
599.12 requirements under section 16C.06.

599.13 Subd. 7. **Eligibility.** (a) To be eligible for the OneCare Buy-In, a person must:

- 599.14 (1) be a resident of Minnesota; and
- 599.15 (2) not be enrolled in government-sponsored programs as defined in United States Code,
- 599.16 title 26, section 5000A(f)(1)(A). For purposes of this subdivision, an applicant who is
- 599.17 enrolled in Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of
- 599.18 the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is
- 599.19 considered enrolled in government-sponsored programs. An applicant shall not refuse to
- 599.20 apply for or enroll in Medicare coverage to establish eligibility for the OneCare Buy-In.
- 599.21 (b) A person who is determined eligible for enrollment in a qualified health plan with
- 599.22 or without advance payments of the premium tax credit and with or without cost-sharing
- 599.23 reductions according to Code of Federal Regulations, title 45, section 155.305, paragraphs
- 599.24 (a), (f), and (g), is eligible to purchase and enroll in the OneCare Buy-In instead of purchasing
- 599.25 a qualified health plan as defined under section 62V.02.
- 599.26 Subd. 8. **Enrollment.** (a) A person may apply for the OneCare Buy-In during the annual
- 599.27 open and special enrollment periods established for MNsure as defined in Code of Federal
- 599.28 Regulations, title 45, sections 155.410 and 155.420, through the MNsure website.
- 599.29 (b) A person must annually reenroll for the OneCare Buy-In during open and special
- 599.30 enrollment periods.
- 600.1 Subd. 9. **Premium tax credits, cost-sharing reductions, and subsidies.** A person who
- 600.2 is eligible under this chapter, and whose income is less than or equal to 400 percent of the
- 600.3 federal poverty guidelines, may qualify for advance premium tax credits and cost-sharing
- 600.4 reductions under Code of Federal Regulations, title 45, section 155.305, paragraphs (a), (f),
- 600.5 and (g), to purchase a health plan established under this chapter.
- 600.6 Subd. 10. **Covered benefits and payment rate modifications.** The commissioner, after
- 600.7 providing public notice and an opportunity for public comment, may modify the covered
- 600.8 benefits and payment rates to carry out this chapter.
- 600.9 Subd. 11. **Provider tax.** Section 295.582, subdivision 1, applies to health plans offered
- 600.10 under the OneCare Buy-In program.
- 600.11 Subd. 12. **Hospital financial reimbursement fund.** The commissioner shall establish
- 600.12 and administer a hospital financial reimbursement fund, to provide grants or supplemental
- 600.13 payments to hospitals, to mitigate the financial effects of uncompensated care caused by
- 600.14 high-deductible health plans.
- 600.15 Subd. 13. **Request for federal authority.** The commissioner shall seek all necessary
- 600.16 federal waivers to establish the OneCare Buy-In under this chapter.
- 600.17 **EFFECTIVE DATE.** (a) Subdivisions 1 to 12 are effective January 1, 2023.
- 600.18 (b) Subdivision 13 is effective the day following final enactment.

600.19 Sec. 20. [256T.03] ONECARE BUY-IN PRODUCTS.

600.20 Subdivision 1. **Platinum product.** The commissioner of human services shall establish
600.21 a OneCare Buy-In coverage option that provides platinum level of coverage in accordance
600.22 with the Affordable Care Act and benefits that are actuarially equivalent to 90 percent of
600.23 the full actuarial value of the benefits provided under the OneCare Buy-In coverage option.
600.24 This product must be made available in all rating areas in the state.

600.25 Subd. 2. **Silver and gold products.** (a) If any rating area lacks an affordable or
600.26 comprehensive health care coverage option according to standards developed by the
600.27 commissioner of health, the following year the commissioner of human services shall offer
600.28 silver and gold products established under paragraph (b) in the rating area for a five-year
600.29 period.

600.30 (b) The commissioner shall establish the following OneCare Buy-In coverage options:
600.31 one coverage option shall provide silver level of coverage in accordance with the Affordable
600.32 Care Act and benefits that are actuarially equivalent to 70 percent of the full actuarial value
601.1 of the benefits provided under the OneCare Buy-In coverage option, and one coverage
601.2 option shall provide gold level of coverage in accordance with the Affordable Care Act and
601.3 benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits
601.4 provided under the OneCare Buy-In coverage option.

601.5 Subd. 3. **Qualified health plan rules.** (a) The coverage options developed under this
601.6 section are subject to the process under section 62K.06. The coverage options developed
601.7 under this section shall meet requirements of chapters 62A, 62K, and 62V that apply to
601.8 qualified health plans.

601.9 (b) The Department of Human Services is not an insurance company for purposes of
601.10 this chapter.

601.11 Subd. 4. **Actuarial value.** Determination of the actuarial value of coverage options under
601.12 this section must be calculated in accordance with Code of Federal Regulations, title 45,
601.13 section 156.135.

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

601.15 Sec. 21. [256T.04] OUTPATIENT PRESCRIPTION DRUGS.

601.16 Subdivision 1. **Establishment of program.** The commissioner shall administer and
601.17 oversee the outpatient prescription drug program for the OneCare Buy-In program. The
601.18 commissioner shall not include the outpatient pharmacy benefit in a contract with a public
601.19 or private entity.

601.20 Subd. 2. **Covered outpatient prescription drugs.** Outpatient prescription drugs are
601.21 covered in accordance with chapter 256L.

- 601.22 Subd. 3. **Pharmacy provider participation.** Pharmacy provider participation shall be
601.23 governed by section 256L.30, subdivision 3.
- 601.24 Subd. 4. **Reimbursement rate.** The commissioner shall establish outpatient prescription
601.25 drug reimbursement rates according to chapter 256L.
- 601.26 Subd. 5. **Prescription drug benefit consumer protections.** Prescription drug benefit
601.27 consumer protections shall be in accordance with section 256L.30, subdivision 5.
- 601.28 **EFFECTIVE DATE.** This section is effective January 1, 2023.
- 602.1 Sec. 22. Minnesota Statutes 2018, section 270B.12, is amended by adding a subdivision
602.2 to read:
- 602.3 Subd. 15. **Board of Directors of MNsure.** The commissioner may disclose return
602.4 information to the extent necessary to the Board of Directors of MNsure to determine
602.5 eligibility under section 62V.12, subdivision 1.
- 602.6 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December
602.7 31, 2020.
- 602.8 Sec. 23. Minnesota Statutes 2018, section 290.0131, is amended by adding a subdivision
602.9 to read:
- 602.10 Subd. 15. **Health insurance premiums.** The amount of health insurance premiums
602.11 deducted on the taxpayer's federal return, to the extent used to calculate the credit under
602.12 section 290.0693, is an addition.
- 602.13 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December
602.14 31, 2020.
- 602.15 Sec. 24. [290.0693] HEALTH INSURANCE PREMIUM CREDIT
- 602.16 Subdivision 1. **Credit allowed.** (a) An individual who is a resident of Minnesota is
602.17 allowed a credit against the tax due under this chapter if the individual would be allowed a
602.18 credit under section 36B of the Internal Revenue Code, except that the individual's household
602.19 income, as defined in section 36B(d)(2) of the Internal Revenue Code, exceeds 400 percent
602.20 of the poverty line for the individual's family size as defined in section 36B(d)(3) of the
602.21 Internal Revenue Code.
- 602.22 (b) In the determination of "coverage month" under section 36B(c)(2) of the Internal
602.23 Revenue Code, section 36B(c)(2)(B) and (C) must not apply.
- 602.24 (c) The credit is equal to what the credit would have been under section 36B of the
602.25 Internal Revenue Code, except the applicable percentage for purposes of section
602.26 36B(b)(2)(B)(ii) of the Internal Revenue Code is the highest premium percentage in section
602.27 36B(b)(3)(A) of the Internal Revenue Code.

602.28 (d) The amount of monthly premiums taken into account under section 36B(b)(2)(A) of
602.29 the Internal Revenue Code must be reduced by the amount of premium subsidy made by
602.30 MNsure and applied to the gross premium.

603.1 Subd. 2. **Advanced payment of credit.** (a) An individual may claim the credit on the
603.2 individual's tax return or have the credit paid in advance pursuant to section 62V.12.

603.3 (b) If an individual elects to have the credit paid in advance, the credit claimed under
603.4 subdivision 1 must be reduced by the amount of the advanced payments. If the amount of
603.5 the advance payments exceeds the amount of credit the individual is eligible for, the tax
603.6 imposed by this chapter for the taxable year must be increased by the amount of the excess.

603.7 (c) If the amount of credit that the individual is allowed under subdivision 1, after
603.8 subtracting any advanced payments, exceeds the individual's tax liability under this chapter,
603.9 the commissioner shall refund the excess to the individual.

603.10 (d) By January 31 of each year, the Board of Directors of MNsure must provide to each
603.11 individual who applied for assistance and enrolled in a qualified health plan and to the
603.12 commissioner a statement containing information on the preceding year necessary to reconcile
603.13 the credit with the advance payments. The Board of Directors of MNsure and the
603.14 commissioner must consult to develop the form and manner of the report.

603.15 (e) Each year, 60 days prior to MNsure's open enrollment, the commissioner shall provide
603.16 information to MNsure about which individuals received an advanced payment of the
603.17 state-based health insurance tax credit under section 62V.12 in a prior taxable year and did
603.18 not file a return and reconcile the payments for that taxable year.

603.19 Subd. 3. **Reporting requirements.** (a) If the individual has a change in eligibility status
603.20 determination by MNsure, after the taxable year is complete, the individual and MNsure
603.21 must notify the commissioner of the change in eligibility within six months of the change.

603.22 (b) Notwithstanding any law to the contrary, the commissioner may recompute the tax
603.23 due based on the determination of eligibility.

603.24 Subd. 4. **Appropriation.** (a) An amount sufficient to pay the refunds required by this
603.25 section is appropriated to the commissioner from the health care access fund.

603.26 (b) \$1,037,000 in fiscal year 2022 and \$880,000 in each fiscal year thereafter are the
603.27 base from the health care access fund to the commissioner of revenue for administering this
603.28 section.

603.29 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December
603.30 31, 2020.

604.1 Sec. 25. Minnesota Statutes 2018, section 295.51, subdivision 1a, is amended to read:

604.2 Subd. 1a. **Nexus in Minnesota.** (a) To the extent allowed by the United States
604.3 Constitution and the laws of the United States, a person who is a wholesale drug distributor

604.4 has nexus in Minnesota if its contacts with or presence in Minnesota is sufficient to satisfy
604.5 the requirements of the United States Constitution, a person who receives legend drugs for
604.6 resale or use in Minnesota other than from a wholesale drug distributor that is subject to
604.7 tax, or a person who sells or repairs hearing aids and related equipment or prescription
604.8 eyewear is subject to the taxes imposed by this chapter if the person:

604.9 (1) has or maintains within this state, directly or by a subsidiary or an affiliate, an office,
604.10 place of distribution, sales, storage, or sample room or place, warehouse, or other place of
604.11 business, including the employment of a resident of this state who works from a home office
604.12 in this state;

604.13 (2) has a representative, including but not limited to an employee, affiliate, agent,
604.14 salesperson, canvasser, solicitor, independent contractor, or other third party operating in
604.15 this state under the person's authority or the authority of the person's subsidiary, for any
604.16 purpose, including the repairing, selling, delivering, installing, facilitating sales, processing
604.17 sales, or soliciting of orders for the person's goods or services, or the leasing of tangible
604.18 personal property located in this state, whether the place of business or the agent,
604.19 representative, affiliate, salesperson, canvasser, or solicitor is located in the state permanently
604.20 or temporarily, or whether or not the person, subsidiary, or affiliate is authorized to do
604.21 business in this state;

604.22 (3) owns or leases real property that is located in this state; or

604.23 (4) owns or leases tangible personal property that is present in this state, including but
604.24 not limited to mobile property.

604.25 (b) To the extent allowed by the United States Constitution and the laws of the United
604.26 States, a person who is a wholesale drug distributor, or a person who receives legend drugs
604.27 for resale or use in Minnesota other than from a wholesale drug distributor that is subject
604.28 to tax, is subject to the taxes imposed by this chapter if the person:

604.29 (1) conducts a trade or business not described in paragraph (a) and sells, delivers, or
604.30 distributes legend drugs from outside this state to a destination within this state by common
604.31 carrier or otherwise; and

604.32 (2) meets one of the following thresholds:

605.1 (i) makes 100 or more sales, deliveries, or distributions described in clause (1) during
605.2 any taxable year;

605.3 (ii) the gross revenues of a wholesale drug distributor that sells or distributes legend
605.4 drugs as described in clause (1) totals more than \$100,000 during any taxable year; or

605.5 (iii) the price paid by a person who receives legend drugs for resale or use in Minnesota
605.6 other than from a wholesale drug distributor that is subject to tax for legend drugs as
605.7 described in clause (1) totals more than \$100,000 during any taxable year.

605.8 (c) To the extent allowed by the United States Constitution and the laws of the United
605.9 States, a person who sells or repairs hearing aids and related equipment or prescription
605.10 eyewear is subject to the taxes imposed by this chapter if the person:

605.11 (1) conducts a trade or business not described in paragraph (a) and:

605.12 (i) sells, delivers, or distributes hearing aids or prescription eyewear from outside of this
605.13 state to a destination within this state by common carrier or otherwise; or

605.14 (ii) repairs hearing aids or prescription eyewear outside of this state and delivers or
605.15 distributes the hearing aids or prescription eyewear to a destination within this state by
605.16 common carrier or otherwise; and

605.17 (2) meets one of the following thresholds:

605.18 (i) makes 100 or more sales, deliveries, distributions, or repairs described in clause (1)
605.19 during any taxable year; or

605.20 (ii) the gross revenues of the person who sells, delivers, distributes, or repairs hearing
605.21 aids or prescription eyewear described in clause (1) totals more than \$100,000 during any
605.22 taxable year.

605.23 (d) Once a taxpayer has established nexus with Minnesota under paragraph (b) or (c),
605.24 the taxpayer must continue to file an annual return and remit taxes for subsequent years. A
605.25 taxpayer who has established nexus under paragraph (b) or (c) is no longer required to file
605.26 an annual return and remit taxes if the taxpayer:

605.27 (1) ceases to engage in the activities, or no longer meets any of the applicable thresholds,
605.28 in paragraph (b) or (c) for an entire taxable year; and

605.29 (2) notifies the commissioner by March 15 of the following calendar year, in a manner
605.30 prescribed by the commissioner, that the taxpayer no longer engages in any of the activities,
605.31 or no longer meets any of the applicable thresholds, in paragraph (b) or (c).

606.1 (e) If, after notifying the commissioner pursuant to paragraph (d), the taxpayer
606.2 subsequently engages in any of the activities, and meets any of the applicable thresholds,
606.3 in paragraph (b) or (c), the taxpayer shall again comply with the applicable requirements
606.4 of paragraphs (b), (c), and (d).

606.5 **EFFECTIVE DATE; APPLICATION.** (a) This section is effective the day following
606.6 final enactment.

606.7 (b) In enacting this section, the legislature confirms that the United States Supreme Court
606.8 decision in South Dakota v. Wayfair, Inc. et al., Dkt. No. 17-494 (June 21, 2018); 138 S.
606.9 Ct. 2080 (2018), applied upon the date of that decision to provide Minnesota with jurisdiction
606.10 over persons described in paragraphs (b) and (c) for purposes of imposing tax under chapter
606.11 295 to the extent allowed by the United States Constitution and the laws of the United States.

606.12 Sec. 26. Minnesota Statutes 2018, section 295.57, subdivision 3, is amended to read:

606.13 Subd. 3. **Interest on overpayments.** Interest must be paid on an overpayment refunded
606.14 or credited to the taxpayer from the date of payment of the tax until the date the refund is
606.15 paid or credited. For purposes of this subdivision, the date of payment is the due date of the
606.16 return or the date of actual payment of the tax, whichever is later in the manner provided
606.17 in section 289A.56, subdivision 2.

606.18 **EFFECTIVE DATE.** This section is effective for overpayments made on or after
606.19 January 1, 2020.

606.20 Sec. 27. Minnesota Statutes 2018, section 295.582, subdivision 1, is amended to read:

606.21 Subdivision 1. **Tax expense transfer.** (a) A hospital, surgical center, or health care
606.22 provider that is subject to a tax under section 295.52, or a pharmacy that has paid additional
606.23 expense transferred under this section by a wholesale drug distributor, may transfer additional
606.24 expense generated by section 295.52 obligations on to all third-party contracts for the
606.25 purchase of health care services on behalf of a patient or consumer. Nothing shall prohibit
606.26 a pharmacy from transferring the additional expense generated under section 295.52 to a
606.27 pharmacy benefits manager. The additional expense transferred to the third-party purchaser
606.28 or a pharmacy benefits manager must not exceed the tax percentage specified in section
606.29 295.52 multiplied against the gross revenues received under the third-party contract, and
606.30 the tax percentage specified in section 295.52 multiplied against co-payments and deductibles
606.31 paid by the individual patient or consumer. The expense must not be generated on revenues
606.32 derived from payments that are excluded from the tax under section 295.53. All third-party
606.33 purchasers of health care services including, but not limited to, third-party purchasers
607.1 regulated under chapter 60A, 62A, 62C, 62D, 62H, 62N, 64B, 65A, 65B, 79, ~~or~~ 79A, or
607.2 256T, or under section 471.61 or 471.617, and pharmacy benefits managers must pay the
607.3 transferred expense in addition to any payments due under existing contracts with the
607.4 hospital, surgical center, pharmacy, or health care provider, to the extent allowed under
607.5 federal law. A third-party purchaser of health care services includes, but is not limited to,
607.6 a health carrier or community integrated service network that pays for health care services
607.7 on behalf of patients or that reimburses, indemnifies, compensates, or otherwise insures
607.8 patients for health care services. For purposes of this section, a pharmacy benefits manager
607.9 means an entity that performs pharmacy benefits management. A third-party purchaser or
607.10 pharmacy benefits manager shall comply with this section regardless of whether the
607.11 third-party purchaser or pharmacy benefits manager is a for-profit, not-for-profit, or nonprofit
607.12 entity. A wholesale drug distributor may transfer additional expense generated by section
607.13 295.52 obligations to entities that purchase from the wholesaler, and the entities must pay
607.14 the additional expense. Nothing in this section limits the ability of a hospital, surgical center,
607.15 pharmacy, wholesale drug distributor, or health care provider to recover all or part of the
607.16 section 295.52 obligation by other methods, including increasing fees or charges.

607.17 (b) Any hospital, surgical center, or health care provider subject to a tax under section
607.18 295.52 or a pharmacy that has paid additional expense transferred under this section by a
607.19 wholesale drug distributor may file a complaint with the commissioner responsible for

607.20 regulating the third-party purchaser if at any time the third-party purchaser fails to comply
607.21 with paragraph (a).

607.22 (c) If the commissioner responsible for regulating the third-party purchaser finds at any
607.23 time that the third-party purchaser has not complied with paragraph (a), the commissioner
607.24 may take enforcement action against a third-party purchaser which is subject to the
607.25 commissioner's regulatory jurisdiction and which does not allow a hospital, surgical center,
607.26 pharmacy, or provider to pass-through the tax. The commissioner may by order fine or
607.27 censure the third-party purchaser or revoke or suspend the certificate of authority or license
607.28 of the third-party purchaser to do business in this state if the commissioner finds that the
607.29 third-party purchaser has not complied with this section. The third-party purchaser may
607.30 appeal the commissioner's order through a contested case hearing in accordance with chapter
607.31 14.

607.32 Sec. 28. Minnesota Statutes 2018, section 297I.05, subdivision 5, is amended to read:

607.33 Subd. 5. **Health maintenance organizations, nonprofit health service plan**
607.34 **corporations, OneCare Buy-In plans, and community integrated service networks.** (a)
608.1 A tax is imposed on health maintenance organizations, community integrated service
608.2 networks, OneCare Buy-In plans established under chapter 256T, and nonprofit health care
608.3 service plan corporations. The rate of tax is equal to one percent of gross premiums less
608.4 return premiums on all direct business received by the organization, network, plan, or
608.5 corporation or its agents in Minnesota, in cash or otherwise, in the calendar year.

608.6 (b) The commissioner shall deposit all revenues, including penalties and interest, collected
608.7 under this chapter from health maintenance organizations, community integrated service
608.8 networks, and nonprofit health service plan corporations in the health care access fund and
608.9 shall deposit all revenues collected from OneCare Buy-In plans in the hospital financial
608.10 reimbursement fund established under section 256T.02, subdivision 12. Refunds of
608.11 overpayments of tax imposed by this subdivision must be paid from the health care access
608.12 fund. There is annually appropriated from the health care access fund to the commissioner
608.13 the amount necessary to make any refunds of the tax imposed under this subdivision.

608.14 **EFFECTIVE DATE.** This section is effective for premiums received on or after January
608.15 1, 2023.

608.16 Sec. 29. **DIRECTION TO COMMISSIONER; STATE-BASED RISK ADJUSTMENT**
608.17 **ANALYSIS.**

608.18 The commissioner of commerce, in consultation with the commissioner of health, shall
608.19 conduct a study on the design and implementation of a state-based risk adjustment program.
608.20 The commissioner shall report on the findings of the study and any recommendations to
608.21 the chairs and ranking minority members of the legislative committees with jurisdiction
608.22 over the individual health insurance market by February 15, 2021.

608.23 Sec. 30. **STUDY OF COST OF PROVIDING DENTAL SERVICES.**

608.24 The commissioner of human services shall contract with a vendor to conduct a survey
608.25 of the cost to Minnesota dental providers of delivering dental services to medical assistance
608.26 and MinnesotaCare enrollees under both fee-for-service and managed care. The commissioner
608.27 of human services shall ensure that the vendor has prior experience in conducting surveys
608.28 of the cost of providing health care services. Each dental provider enrolled with the
608.29 department must respond to the cost of service survey. The commissioner of human services
608.30 may sanction a dental provider under Minnesota Statutes, section 256B.064, for failure to
608.31 respond. The commissioner of human services shall require the vendor to measure statewide
608.32 and regional costs for both fee-for-service and managed care, by major dental service
608.33 category and for the most common dental services. The commissioner of human services
609.1 shall post a copy of the final survey report on the department's website. The initial survey
609.2 must be completed no later than January 1, 2021, and the survey must be repeated every
609.3 three years. The commissioner of human services shall provide a summary of the results of
609.4 each cost of dental services survey and provide recommendations for any changes to dental
609.5 payment rates to the chairs and ranking members of the legislative committees with
609.6 jurisdiction over health and human services policy and finance.

609.7 Sec. 31. **OUTPATIENT PHARMACY BENEFIT FOR ENROLLEES OF HEALTH**
609.8 **PLAN COMPANIES.**

609.9 (a) The commissioner of human services shall develop a plan for an outpatient pharmacy
609.10 benefit to be administered by the commissioner of human services for enrollees of health
609.11 plan companies. The plan must:

609.12 (1) provide prescription drug coverage, beginning January 1, 2022, to the enrollees of
609.13 health plan companies that choose to participate in the pharmacy benefit program;

609.14 (2) provide coverage and reimbursement for outpatient prescription drugs in accordance
609.15 with Minnesota Statutes, chapter 256L;

609.16 (3) require the commissioner to annually determine and publish the monthly premium
609.17 per enrollee for prescription drug coverage by August 1 of each year, for coverage taking
609.18 effect the following January 1;

609.19 (4) establish different co-payments for each of the following categories: preferred generic
609.20 drugs; preferred branded drugs; nonpreferred generic drugs; nonpreferred branded drugs;
609.21 and specialty drugs; and

609.22 (5) require a health plan company that enters into a contract with the commissioner to
609.23 participate in the program to pay the commissioner for all costs incurred in providing a
609.24 prescription drug benefit, including costs related to benefit administration and the purchasing
609.25 of prescription drugs.

609.26 (b) The commissioner shall present the plan to the chairs and ranking minority members
609.27 of the legislative committees with jurisdiction over health and human services policy and
609.28 finance and health insurance by December 15, 2019.

609.29 Sec. 32. **BENEFIT AND COST ANALYSIS OF A UNIFIED HEALTH CARE**
609.30 **FINANCING SYSTEM.**

609.31 Subdivision 1. **Contract for analysis of proposal.** The commissioner of health shall
609.32 contract with the University of Minnesota School of Public Health to conduct an analysis
610.1 of the current health care financing environment and evaluate whether a unified health care
610.2 financing system would provide better access to care, reduce or slow the rate of increase in
610.3 total health care spending, and provide other benefits to individuals, businesses, and the
610.4 state economy, relative to the current health care financing environment.

610.5 Subd. 2. **Proposal.** The analysis shall include recommendations for a framework for a
610.6 unified health care financing system designed to:

610.7 (1) ensure all Minnesotans have access to all necessary primary and specialty care,
610.8 including dental, vision and hearing, mental health, chemical dependency treatment,
610.9 prescription drugs, medical equipment and supplies, long-term, and home care;

610.10 (2) maximize the ability for patients to choose doctors, hospitals, and other providers;
610.11 and

610.12 (3) incentivize a focus on preventative care and public health, including social
610.13 determinants of health and care coordination.

610.14 Subd. 3. **Proposal analysis.** (a) The analysis must forecast over a ten-year or longer
610.15 period determined to be sufficient to capture all benefits and costs of the unified health care
610.16 financing system. The analysis must compare and contrast the impact of the proposed health
610.17 care financing system and the current health care financing environment on:

610.18 (1) the number of people covered versus the number of people who continue to lack
610.19 access to health care because of financial or other barriers, if any;

610.20 (2) the completeness of the coverage and the number of people lacking coverage for
610.21 dental, long-term care, medical equipment or supplies, vision and hearing, or other health
610.22 services that are not covered, if any;

610.23 (3) the adequacy of the coverage, the level of underinsured in the state, and whether
610.24 people with coverage can afford the care they need or whether cost prevents them from
610.25 accessing care;

610.26 (4) the timeliness and appropriateness of the care received and whether people turn to
610.27 less appropriate care such as emergency rooms because of a lack of proper care in accordance
610.28 with clinical guidelines; and

610.29 (5) total public and private health care spending in Minnesota under the current health
610.30 care financing environment versus a unified health care financing system, including all
610.31 spending by individuals, businesses, and government. "Total public and private health care
610.32 spending" means spending on all medical care including but not limited to dental, vision
610.33 and hearing, mental health, chemical dependency treatment, prescription drugs, medical

611.1 equipment and supplies, long-term care, and home care, whether paid through premiums,
611.2 co-pays and deductibles, other out-of-pocket payments, or other funding from government,
611.3 employers, or other sources. Total public and private health care spending also includes the
611.4 costs associated with administering, delivering, and paying for the care. The costs of
611.5 administering, delivering, and paying for the care includes all expenses by insurers, providers,
611.6 employers, individuals, and government to select, negotiate, purchase, and administer
611.7 insurance and care including but not limited to coverage for health care, dental, prescription
611.8 drugs, medical expense portions of workers compensation and automobile insurance, and
611.9 the cost of administering and paying for all health care products and services that are not
611.10 covered by insurance. The analysis of total health care spending shall examine, to the extent
611.11 possible given available data and resources, whether there are savings or additional costs
611.12 under the proposed health care financing system compared to the existing health care
611.13 financing environment due to:

611.14 (i) reduced insurance, billing, underwriting, marketing, evaluation, and other
611.15 administrative functions including savings from global budgeting for hospitals and
611.16 institutional care instead of billing for individual services provided;

611.17 (ii) reduced prices on medical services and products including pharmaceuticals due to
611.18 price negotiations, if applicable under the proposal;

611.19 (iii) shortages or excess capacity of medical facilities and equipment;

611.20 (iv) changes in utilization, better health outcomes, and reduced time away from work
611.21 due to prevention, early intervention, and health-promoting activities; and

611.22 (v) the impact on state, local, and federal government non-health-care expenditures,
611.23 such as reduced demand for public services and reduced out-of-home placement costs due
611.24 to increased access to mental health and chemical dependency services.

611.25 (b) The analysis shall assume that operation of the unified health care financing system
611.26 is not preempted by federal law.

611.27 (c) The commissioner shall issue a final report by January 15, 2021, and may provide
611.28 interim reports and status updates to the governor and the chairs and ranking minority
611.29 members of the legislative committees with jurisdiction over health and human services
611.30 policy and finance.

611.31 **Sec. 33. RATE CHANGES AND DENTAL ACCESS.**

611.32 The commissioner of human services, in consultation with stakeholders, including the
611.33 Health Services Policy Committee established in Minnesota Statutes, section 256B.0625,
612.1 subdivision 3c, shall analyze the impact of the dental rate changes in this article that take
612.2 effect January 1, 2022, to evaluate the impact on access to dental services for medical
612.3 assistance and MinnesotaCare program participants. The analysis may recommend changes
612.4 to payment methodologies. In evaluating access, the analysis shall at a minimum consider
612.5 distance traveled by enrollees, access to regular and urgent dental care, and the availability

- 612.6 of a dental home. The analysis shall consider the impact of any changes on the providers
612.7 currently enrolled in the medical assistance and MinnesotaCare programs as well as the
612.8 potential impact on providers who currently do not participate. Any changes to payment
612.9 methodologies recommended as part of this analysis must include a comprehensive, uniform
612.10 rate for the provision of dental services for all recipients of medical assistance and
612.11 MinnesotaCare, prioritizing access to both preventative and restorative dental services
612.12 among children under age 21. The commissioner shall provide, to the chairs and ranking
612.13 minority members of the legislative committees with jurisdiction over health and human
612.14 services policy and finance, a preliminary report on the results of the analysis by December
612.15 1, 2019, and a final report and any recommendations by December 1, 2020.
- 612.16 Sec. 34. **REPEALER.**
- 612.17 Minnesota Statutes 2018, section 256L.11, subdivision 6a, is repealed.
- 612.18 **EFFECTIVE DATE.** This section is effective January 1, 2022.