

511.10 **ARTICLE 8**

511.11 **HEALTH CARE**

511.12 Section 1. Minnesota Statutes 2018, section 13.69, subdivision 1, is amended to read:

511.13 Subdivision 1. **Classifications.** (a) The following government data of the Department

511.14 of Public Safety are private data:

511.15 (1) medical data on driving instructors, licensed drivers, and applicants for parking

511.16 certificates and special license plates issued to physically disabled persons;

511.17 (2) other data on holders of a disability certificate under section 169.345, except that (i)

511.18 data that are not medical data may be released to law enforcement agencies, and (ii) data

511.19 necessary for enforcement of sections 169.345 and 169.346 may be released to parking

511.20 enforcement employees or parking enforcement agents of statutory or home rule charter

511.21 cities and towns;

511.22 (3) Social Security numbers in driver's license and motor vehicle registration records,

511.23 except that Social Security numbers must be provided to the Department of Revenue for

511.24 purposes of tax administration, the Department of Labor and Industry for purposes of

511.25 workers' compensation administration and enforcement, the judicial branch for purposes of

511.26 debt collection, and the Department of Natural Resources for purposes of license application

511.27 administration, and except that the last four digits of the Social Security number must be

511.28 provided to the Department of Human Services for purposes of recovery of Minnesota health

511.29 care program benefits paid; and

511.30 (4) data on persons listed as standby or temporary custodians under section 171.07,

511.31 subdivision 11, except that the data must be released to:

512.1 (i) law enforcement agencies for the purpose of verifying that an individual is a designated

512.2 caregiver; or

512.3 (ii) law enforcement agencies who state that the license holder is unable to communicate

512.4 at that time and that the information is necessary for notifying the designated caregiver of

512.5 the need to care for a child of the license holder.

512.6 The department may release the Social Security number only as provided in clause (3)

512.7 and must not sell or otherwise provide individual Social Security numbers or lists of Social

512.8 Security numbers for any other purpose.

512.9 (b) The following government data of the Department of Public Safety are confidential

512.10 data: data concerning an individual's driving ability when that data is received from a member

512.11 of the individual's family.

512.12 **EFFECTIVE DATE.** This section is effective July 1, 2019.

265.18 **ARTICLE 8**

265.19 **DEPARTMENT OF HUMAN SERVICES; HEALTH CARE**

265.20 Section 1. Minnesota Statutes 2018, section 13.69, subdivision 1, is amended to read:

265.21 Subdivision 1. **Classifications.** (a) The following government data of the Department

265.22 of Public Safety are private data:

265.23 (1) medical data on driving instructors, licensed drivers, and applicants for parking

265.24 certificates and special license plates issued to physically disabled persons;

265.25 (2) other data on holders of a disability certificate under section 169.345, except that (i)

265.26 data that are not medical data may be released to law enforcement agencies, and (ii) data

265.27 necessary for enforcement of sections 169.345 and 169.346 may be released to parking

265.28 enforcement employees or parking enforcement agents of statutory or home rule charter

265.29 cities and towns;

266.1 (3) Social Security numbers in driver's license and motor vehicle registration records,

266.2 except that Social Security numbers must be provided to the Department of Revenue for

266.3 purposes of tax administration, the Department of Labor and Industry for purposes of

266.4 workers' compensation administration and enforcement, the judicial branch for purposes of

266.5 debt collection, and the Department of Natural Resources for purposes of license application

266.6 administration, and except that the last four digits of the Social Security number must be

266.7 provided to the Department of Human Services for purposes of recovery of Minnesota health

266.8 care program benefits paid; and

266.9 (4) data on persons listed as standby or temporary custodians under section 171.07,

266.10 subdivision 11, except that the data must be released to:

266.11 (i) law enforcement agencies for the purpose of verifying that an individual is a designated

266.12 caregiver; or

266.13 (ii) law enforcement agencies who state that the license holder is unable to communicate

266.14 at that time and that the information is necessary for notifying the designated caregiver of

266.15 the need to care for a child of the license holder.

266.16 The department may release the Social Security number only as provided in clause (3)

266.17 and must not sell or otherwise provide individual Social Security numbers or lists of Social

266.18 Security numbers for any other purpose.

266.19 (b) The following government data of the Department of Public Safety are confidential

266.20 data: data concerning an individual's driving ability when that data is received from a member

266.21 of the individual's family.

512.13 Sec. 2. Minnesota Statutes 2018, section 16A.724, subdivision 2, is amended to read:

512.14 Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources  
 512.15 in the health care access fund exceed expenditures in that fund, effective for the biennium  
 512.16 beginning July 1, 2007, the commissioner of management and budget shall transfer the  
 512.17 excess funds from the health care access fund to the general fund on June 30 of each year,  
 512.18 provided that the amount transferred in fiscal year 2016 shall not exceed \$48,000,000, the  
 512.19 amount in fiscal year 2017 shall not exceed \$122,000,000, and the amount in any fiscal  
 512.20 biennium thereafter shall not exceed \$244,000,000. The purpose of this transfer is to meet  
 512.21 the rate increase required under Laws 2003, First Special Session chapter 14, article 13C,  
 512.22 section 2, subdivision 6 section 256B.0625, subdivision 67.

512.23 (b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if  
 512.24 necessary, the commissioner shall reduce these transfers from the health care access fund  
 512.25 to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer  
 512.26 sufficient funds from the general fund to the health care access fund to meet annual  
 512.27 MinnesotaCare expenditures.

512.28 Sec. 3. Minnesota Statutes 2018, section 62A.671, subdivision 6, is amended to read:

512.29 Subd. 6. **Licensed health care provider.** "Licensed health care provider" means a health  
 512.30 care provider who is:

512.31 (1) licensed under chapter 147, 147A, 148, 148B, 148E, 148F, 150A, or 153; a mental  
 512.32 health professional as defined under section 245.462, subdivision 18, or 245.4871,  
 513.1 subdivision 27; a community health worker meeting the criteria specified in section  
 513.2 256B.0625, subdivision 49, paragraph (a); or vendor of medical care defined in section  
 513.3 256B.02, subdivision 7; and

513.4 (2) authorized within their respective scope of practice to provide the particular service  
 513.5 with no supervision or under general supervision.

513.6 Sec. 4. Minnesota Statutes 2018, section 62Q.184, subdivision 1, is amended to read:

513.7 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this  
 513.8 subdivision have the meanings given them.

513.9 (b) "Clinical practice guideline" means a systematically developed statement to assist  
 513.10 health care providers and enrollees in making decisions about appropriate health care services  
 513.11 for specific clinical circumstances and conditions developed independently of a health plan  
 513.12 company, pharmaceutical manufacturer, or any entity with a conflict of interest. A clinical  
 513.13 practice guideline also includes a preferred drug list developed in accordance with section  
 513.14 256B.0625.

513.15 (c) "Clinical review criteria" means the written screening procedures, decision abstracts,  
 513.16 clinical protocols, and clinical practice guidelines used by a health plan company to determine  
 513.17 the medical necessity and appropriateness of health care services.

513.18 (d) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, but  
513.19 ~~does not include a managed care organization or~~ also includes a county-based purchasing  
513.20 plan participating in a public program under chapter 256B or 256L, ~~or~~ and an integrated  
513.21 health partnership under section 256B.0755.

513.22 (e) "Step therapy protocol" means a protocol or program that establishes the specific  
513.23 sequence in which prescription drugs for a specified medical condition, including  
513.24 self-administered and physician-administered drugs, are medically appropriate for a particular  
513.25 enrollee and are covered under a health plan.

513.26 (f) "Step therapy override" means that the step therapy protocol is overridden in favor  
513.27 of coverage of the selected prescription drug of the prescribing health care provider because  
513.28 at least one of the conditions of subdivision 3, paragraph (a), exists.

513.29 Sec. 5. Minnesota Statutes 2018, section 62Q.184, subdivision 3, is amended to read:

513.30 Subd. 3. **Step therapy override process; transparency.** (a) When coverage of a  
513.31 prescription drug for the treatment of a medical condition is restricted for use by a health  
513.32 plan company through the use of a step therapy protocol, enrollees and prescribing health  
514.1 care providers shall have access to a clear, readily accessible, and convenient process to  
514.2 request a step therapy override. The process shall be made easily accessible on the health  
514.3 plan company's website. A health plan company may use its existing medical exceptions  
514.4 process to satisfy this requirement. A health plan company shall grant an override to the  
514.5 step therapy protocol if at least one of the following conditions exist:

514.6 (1) the prescription drug required under the step therapy protocol is contraindicated  
514.7 pursuant to the pharmaceutical manufacturer's prescribing information for the drug or, due  
514.8 to a documented adverse event with a previous use or a documented medical condition,  
514.9 including a comorbid condition, is likely to do any of the following:

514.10 (i) cause an adverse reaction to the enrollee;

514.11 (ii) decrease the ability of the enrollee to achieve or maintain reasonable functional  
514.12 ability in performing daily activities; or

514.13 (iii) cause physical or mental harm to the enrollee;

514.14 (2) the enrollee has had a trial of the required prescription drug covered by their current  
514.15 or previous health plan, or another prescription drug in the same pharmacologic class or  
514.16 with the same mechanism of action, and was adherent during such trial for a period of time  
514.17 sufficient to allow for a positive treatment outcome, and the prescription drug was  
514.18 discontinued by the enrollee's health care provider due to lack of effectiveness, or an adverse  
514.19 event. This clause does not prohibit a health plan company from requiring an enrollee to  
514.20 try another drug in the same pharmacologic class or with the same mechanism of action if  
514.21 that therapy sequence is supported by the evidence-based and peer-reviewed clinical practice  
514.22 guideline, Food and Drug Administration label, or pharmaceutical manufacturer's prescribing  
514.23 information; or

514.24 (3) the enrollee is currently receiving a positive therapeutic outcome on a prescription  
514.25 drug for the medical condition under consideration if, while on their current health plan or  
514.26 the immediately preceding health plan, the enrollee received coverage for the prescription  
514.27 drug and the enrollee's prescribing health care provider gives documentation to the health  
514.28 plan company that the change in prescription drug required by the step therapy protocol is  
514.29 expected to be ineffective or cause harm to the enrollee based on the known characteristics  
514.30 of the specific enrollee and the known characteristics of the required prescription drug.

514.31 (b) Upon granting a step therapy override, a health plan company shall authorize coverage  
514.32 for the prescription drug if the prescription drug is a covered prescription drug under the  
514.33 enrollee's health plan.

515.1 (c) The enrollee, or the prescribing health care provider if designated by the enrollee,  
515.2 may appeal the denial of a step therapy override by a health plan company using the  
515.3 complaint procedure under sections 62Q.68 to 62Q.73 or 256.045.

515.4 (d) In a denial of an override request and any subsequent appeal, a health plan company's  
515.5 decision must specifically state why the step therapy override request did not meet the  
515.6 condition under paragraph (a) cited by the prescribing health care provider in requesting  
515.7 the step therapy override and information regarding the procedure to request external review  
515.8 of the denial pursuant to section 62Q.73. A denial of a request for a step therapy override  
515.9 that is upheld on appeal is a final adverse determination for purposes of section 62Q.73 and  
515.10 is eligible for a request for external review by an enrollee pursuant to section 62Q.73.

515.11 (e) A health plan company shall respond to a step therapy override request or an appeal  
515.12 within five days of receipt of a complete request. In cases where exigent circumstances  
515.13 exist, a health plan company shall respond within 72 hours of receipt of a complete request.  
515.14 If a health plan company does not send a response to the enrollee or prescribing health care  
515.15 provider if designated by the enrollee within the time allotted, the override request or appeal  
515.16 is granted and binding on the health plan company.

515.17 (f) Step therapy override requests must be accessible to and submitted by health care  
515.18 providers, and accepted by group purchasers electronically through secure electronic  
515.19 transmission, as described under section 62J.497, subdivision 5.

515.20 (g) Nothing in this section prohibits a health plan company from:

515.21 (1) requesting relevant documentation from an enrollee's medical record in support of  
515.22 a step therapy override request; or

515.23 (2) requiring an enrollee to try a generic equivalent drug pursuant to section 151.21, or  
515.24 a biosimilar, as defined under United States Code, chapter 42, section 262(i)(2), prior to  
515.25 providing coverage for the equivalent branded prescription drug.

515.26 (h) This section shall not be construed to allow the use of a pharmaceutical sample for  
515.27 the primary purpose of meeting the requirements for a step therapy override.

515.28 Sec. 6. **[214.078] PROTECTION FROM CONVERSION THERAPY.**

515.29 Subdivision 1. **Definition.** "Conversion therapy" means any practice by a mental health  
515.30 practitioner or mental health professional as defined in section 245.462 that seeks to change  
515.31 an individual's sexual orientation or gender identity, including efforts to change behaviors  
515.32 or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings  
515.33 toward individuals of the same gender. Conversion therapy does not include counseling  
516.1 that provides assistance to an individual undergoing gender transition, or counseling that  
516.2 provides acceptance, support, and understanding of an individual or facilitates an individual's  
516.3 coping, social support, and identity exploration and development, including  
516.4 sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe  
516.5 sexual practices, as long as the counseling does not seek to change an individual's sexual  
516.6 orientation or gender identity.

516.7 Subd. 2. **Prohibition.** (a) No mental health practitioner or mental health professional  
516.8 shall engage in conversion therapy with a client younger than 18 years of age or with a  
516.9 vulnerable adult as defined in section 626.5572, subdivision 21.

516.10 (b) Conversion therapy attempted by a mental health practitioner or mental health  
516.11 professional with a client younger than 18 years of age or with vulnerable adults shall be  
516.12 considered unprofessional conduct and the mental health practitioner or mental health  
516.13 professional may be subject to disciplinary action by the licensing board of the mental health  
516.14 practitioner or mental health professional.

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

516.16 Sec. 7. Minnesota Statutes 2018, section 245A.02, subdivision 5a, is amended to read:

516.17 Subd. 5a. **Controlling individual.** (a) "Controlling individual" means an owner of a  
516.18 program or service provider licensed under this chapter and the following individuals, if  
516.19 applicable:

516.20 (1) each officer of the organization, including the chief executive officer and chief  
516.21 financial officer;

516.22 (2) the individual designated as the authorized agent under section 245A.04, subdivision  
516.23 1, paragraph (b);

516.24 (3) the individual designated as the compliance officer under section 256B.04, subdivision  
516.25 21, paragraph (b) (g); and

516.26 (4) each managerial official whose responsibilities include the direction of the  
516.27 management or policies of a program.

516.28 (b) Controlling individual does not include:

516.29 (1) a bank, savings bank, trust company, savings association, credit union, industrial  
 516.30 loan and thrift company, investment banking firm, or insurance company unless the entity  
 516.31 operates a program directly or through a subsidiary;

517.1 (2) an individual who is a state or federal official, or state or federal employee, or a  
 517.2 member or employee of the governing body of a political subdivision of the state or federal  
 517.3 government that operates one or more programs, unless the individual is also an officer,  
 517.4 owner, or managerial official of the program, receives remuneration from the program, or  
 517.5 owns any of the beneficial interests not excluded in this subdivision;

517.6 (3) an individual who owns less than five percent of the outstanding common shares of  
 517.7 a corporation;

517.8 (i) whose securities are exempt under section 80A.45, clause (6); or

517.9 (ii) whose transactions are exempt under section 80A.46, clause (2);

517.10 (4) an individual who is a member of an organization exempt from taxation under section  
 517.11 290.05, unless the individual is also an officer, owner, or managerial official of the program  
 517.12 or owns any of the beneficial interests not excluded in this subdivision. This clause does  
 517.13 not exclude from the definition of controlling individual an organization that is exempt from  
 517.14 taxation; or

517.15 (5) an employee stock ownership plan trust, or a participant or board member of an  
 517.16 employee stock ownership plan, unless the participant or board member is a controlling  
 517.17 individual according to paragraph (a).

517.18 (c) For purposes of this subdivision, "managerial official" means an individual who has  
 517.19 the decision-making authority related to the operation of the program, and the responsibility  
 517.20 for the ongoing management of or direction of the policies, services, or employees of the  
 517.21 program. A site director who has no ownership interest in the program is not considered to  
 517.22 be a managerial official for purposes of this definition.

517.23 **EFFECTIVE DATE.** This section is effective July 1, 2019.

517.24 Sec. 8. Minnesota Statutes 2018, section 245D.081, subdivision 3, is amended to read:

517.25 Subd. 3. **Program management and oversight.** (a) The license holder must designate  
 517.26 a managerial staff person or persons to provide program management and oversight of the  
 517.27 services provided by the license holder. The designated manager is responsible for the  
 517.28 following:

517.29 (1) maintaining a current understanding of the licensing requirements sufficient to ensure  
 517.30 compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph  
 517.31 (e), and when applicable, as identified in section 256B.04, subdivision 21, paragraph ~~(b)~~  
 517.32 ~~(g)~~;

518.1 (2) ensuring the duties of the designated coordinator are fulfilled according to the  
518.2 requirements in subdivision 2;

518.3 (3) ensuring the program implements corrective action identified as necessary by the  
518.4 program following review of incident and emergency reports according to the requirements  
518.5 in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of  
518.6 alleged or suspected maltreatment must be conducted according to the requirements in  
518.7 section 245A.65, subdivision 1, paragraph (b);

518.8 (4) evaluation of satisfaction of persons served by the program, the person's legal  
518.9 representative, if any, and the case manager, with the service delivery and progress ~~towards~~  
518.10 toward accomplishing outcomes identified in sections 245D.07 and 245D.071, and ensuring  
518.11 and protecting each person's rights as identified in section 245D.04;

518.12 (5) ensuring staff competency requirements are met according to the requirements in  
518.13 section 245D.09, subdivision 3, and ensuring staff orientation and training is provided  
518.14 according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

518.15 (6) ensuring corrective action is taken when ordered by the commissioner and that the  
518.16 terms and conditions of the license and any variances are met; and

518.17 (7) evaluating the information identified in clauses (1) to (6) to develop, document, and  
518.18 implement ongoing program improvements.

518.19 (b) The designated manager must be competent to perform the duties as required and  
518.20 must minimally meet the education and training requirements identified in subdivision 2,  
518.21 paragraph (b), and have a minimum of three years of supervisory level experience in a  
518.22 program providing direct support services to persons with disabilities or persons age 65 and  
518.23 older.

518.24 **EFFECTIVE DATE.** This section is effective July 1, 2019.

266.22 Sec. 2. **[254A.21] FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION**  
266.23 **GRANTS.**

266.24 (a) The commissioner of human services shall award a grant to a statewide organization  
266.25 that focuses solely on prevention of and intervention with fetal alcohol spectrum disorders.  
266.26 The grant recipient must make subgrants to eligible regional collaboratives in rural and  
266.27 urban areas of the state for the purposes specified in paragraph (c).

266.28 (b) "Eligible regional collaboratives" means a partnership between at least one local  
266.29 government and at least one community-based organization and, where available, a family  
266.30 home visiting program. For purposes of this paragraph, a local government includes a county  
266.31 or a multicounty organization, a tribal government, a county-based purchasing entity, or a  
266.32 community health board.



518.25 Sec. 9. Minnesota Statutes 2018, section 256.962, subdivision 5, is amended to read:

518.26 Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish

518.27 an incentive program for organizations and licensed insurance producers under chapter 60K

518.28 that directly identify and assist potential enrollees in filling out and submitting an application.

518.29 For each applicant who is successfully enrolled in MinnesotaCare or medical assistance,

518.30 the commissioner, within the available appropriation, shall pay the organization or licensed

518.31 insurance producer a ~~\$25~~ \$70 application assistance bonus. The organization or licensed

518.32 insurance producer may provide an applicant a gift certificate or other incentive upon

518.33 enrollment.

519.1 **EFFECTIVE DATE.** This section is effective July 1, 2019.

519.2 Sec. 10. Minnesota Statutes 2018, section 256.969, subdivision 2b, is amended to read:

519.3 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November

519.4 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according

519.5 to the following:

519.6 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based

519.7 methodology;

519.8 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology

519.9 under subdivision 25;

519.10 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation

519.11 distinct parts as defined by Medicare shall be paid according to the methodology under

519.12 subdivision 12; and

519.13 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

267.1 (c) Eligible regional collaboratives must use subgrant funds to reduce the incidence of

267.2 fetal alcohol spectrum disorders and other prenatal drug-related effects in children in

267.3 Minnesota by identifying and serving pregnant women suspected of or known to use or

267.4 abuse alcohol or other drugs. Eligible regional collaboratives must provide intensive services

267.5 to chemically dependent women to increase positive birth outcomes.

267.6 (d) An eligible regional collaborative that receives a subgrant under this section must

267.7 report to the grant recipient by January 15 of each year on the services and programs funded

267.8 by the subgrant. The report must include measurable outcomes for the previous year,

267.9 including the number of pregnant women served and the number of toxic-free babies born.

267.10 The grant recipient must compile the information in the subgrant reports and submit a

267.11 summary report to the commissioner of human services by February 15 of each year.

FOR SECTION 3, SEE ARTICLE 5 SIDE BY SIDE.

FOR SECTIONS 4 AND 5, SEE ARTICLE 10 SIDE BY SIDE.



519.14 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not  
519.15 be rebased, except that a Minnesota long-term hospital shall be rebased effective January  
519.16 1, 2011, based on its most recent Medicare cost report ending on or before September 1,  
519.17 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on  
519.18 December 31, 2010. For rate setting periods after November 1, 2014, in which the base  
519.19 years are updated, a Minnesota long-term hospital's base year shall remain within the same  
519.20 period as other hospitals.

519.21 (c) Effective for discharges occurring on and after November 1, 2014, payment rates  
519.22 for hospital inpatient services provided by hospitals located in Minnesota or the local trade  
519.23 area, except for the hospitals paid under the methodologies described in paragraph (a),  
519.24 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a  
519.25 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall  
519.26 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring  
519.27 that the total aggregate payments under the rebased system are equal to the total aggregate  
519.28 payments that were made for the same number and types of services in the base year. Separate  
519.29 budget neutrality calculations shall be determined for payments made to critical access  
519.30 hospitals and payments made to hospitals paid under the DRG system. Only the rate increases  
519.31 or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during  
519.32 the entire base period shall be incorporated into the budget neutrality calculation.

520.1 (d) For discharges occurring on or after November 1, 2014, through the next rebasing  
520.2 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph  
520.3 (a), clause (4), shall include adjustments to the projected rates that result in no greater than  
520.4 a five percent increase or decrease from the base year payments for any hospital. Any  
520.5 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)  
520.6 shall maintain budget neutrality as described in paragraph (c).

520.7 (e) For discharges occurring on or after November 1, 2014, ~~through the next two rebasing~~  
520.8 ~~periods~~ the commissioner may make additional adjustments to the rebased rates, and when  
520.9 evaluating whether additional adjustments should be made, the commissioner shall consider  
520.10 the impact of the rates on the following:

520.11 (1) pediatric services;

520.12 (2) behavioral health services;

520.13 (3) trauma services as defined by the National Uniform Billing Committee;

520.14 (4) transplant services;

520.15 (5) obstetric services, newborn services, and behavioral health services provided by  
520.16 hospitals outside the seven-county metropolitan area;

520.17 (6) outlier admissions;

520.18 (7) low-volume providers; and

520.19 (8) services provided by small rural hospitals that are not critical access hospitals.

520.20 (f) Hospital payment rates established under paragraph (c) must incorporate the following:

520.21 (1) for hospitals paid under the DRG methodology, the base year payment rate per

520.22 admission is standardized by the applicable Medicare wage index and adjusted by the

520.23 hospital's disproportionate population adjustment;

520.24 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,

520.25 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on

520.26 October 31, 2014;

520.27 (3) the cost and charge data used to establish hospital payment rates must only reflect

520.28 inpatient services covered by medical assistance; and

520.29 (4) in determining hospital payment rates for discharges occurring on or after the rate

520.30 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per

520.31 discharge shall be based on the cost-finding methods and allowable costs of the Medicare

521.1 program in effect during the base year or years. In determining hospital payment rates for

521.2 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding

521.3 methods and allowable costs of the Medicare program in effect during the base year or

521.4 years.

521.5 (g) The commissioner shall validate the rates effective November 1, 2014, by applying

521.6 the rates established under paragraph (c), and any adjustments made to the rates under

521.7 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the

521.8 total aggregate payments for the same number and types of services under the rebased rates

521.9 are equal to the total aggregate payments made during calendar year 2013.

521.10 (h) Effective for discharges occurring on or after July 1, 2017, and every two years

521.11 thereafter, payment rates under this section shall be rebased to reflect only those changes

521.12 in hospital costs between the existing base year and the next base year. Changes in costs

521.13 between base years shall be measured using the lower of the hospital cost index defined in

521.14 subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per

521.15 claim. The commissioner shall establish the base year for each rebasing period considering

521.16 the most recent year for which filed Medicare cost reports are available. The estimated

521.17 change in the average payment per hospital discharge resulting from a scheduled rebasing

521.18 must be calculated and made available to the legislature by January 15 of each year in which

521.19 rebasing is scheduled to occur, and must include by hospital the differential in payment

521.20 rates compared to the individual hospital's costs.

521.21 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates

521.22 for critical access hospitals located in Minnesota or the local trade area shall be determined

521.23 using a new cost-based methodology. The commissioner shall establish within the

521.24 methodology tiers of payment designed to promote efficiency and cost-effectiveness.

521.25 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed

521.26 the total cost for critical access hospitals as reflected in base year cost reports. Until the

521.27 next rebasing that occurs, the new methodology shall result in no greater than a five percent  
521.28 decrease from the base year payments for any hospital, except a hospital that had payments  
521.29 that were greater than 100 percent of the hospital's costs in the base year shall have their  
521.30 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and  
521.31 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor  
521.32 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not  
521.33 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the  
521.34 following criteria:

522.1 (1) hospitals that had payments at or below 80 percent of their costs in the base year  
522.2 shall have a rate set that equals 85 percent of their base year costs;

522.3 (2) hospitals that had payments that were above 80 percent, up to and including 90  
522.4 percent of their costs in the base year shall have a rate set that equals 95 percent of their  
522.5 base year costs; and

522.6 (3) hospitals that had payments that were above 90 percent of their costs in the base year  
522.7 shall have a rate set that equals 100 percent of their base year costs.

522.8 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals  
522.9 to coincide with the next rebasing under paragraph (h). The factors used to develop the new  
522.10 methodology may include, but are not limited to:

522.11 (1) the ratio between the hospital's costs for treating medical assistance patients and the  
522.12 hospital's charges to the medical assistance program;

522.13 (2) the ratio between the hospital's costs for treating medical assistance patients and the  
522.14 hospital's payments received from the medical assistance program for the care of medical  
522.15 assistance patients;

522.16 (3) the ratio between the hospital's charges to the medical assistance program and the  
522.17 hospital's payments received from the medical assistance program for the care of medical  
522.18 assistance patients;

522.19 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

522.20 (5) the proportion of that hospital's costs that are administrative and trends in  
522.21 administrative costs; and

522.22 (6) geographic location.

522.23 Sec. 11. Minnesota Statutes 2018, section 256.969, subdivision 3a, is amended to read:

522.24 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program  
522.25 must not be submitted until the recipient is discharged. However, the commissioner shall  
522.26 establish monthly interim payments for inpatient hospitals that have individual patient  
522.27 lengths of stay over 30 days regardless of diagnostic category. Except as provided in section  
522.28 256.9693, medical assistance reimbursement for treatment of mental illness shall be

522.29 reimbursed based on diagnostic classifications. Individual hospital payments established  
522.30 under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party  
522.31 and recipient liability, for discharges occurring during the rate year shall not exceed, ~~in~~  
522.32 ~~aggregate~~ on a per claim basis, the charges for the medical assistance covered inpatient  
523.1 services paid for the same period of time to the hospital. Services that have rates established  
523.2 under subdivision 12, must be limited separately from other services. After consulting with  
523.3 the affected hospitals, the commissioner may consider related hospitals one entity and may  
523.4 merge the payment rates while maintaining separate provider numbers. The operating and  
523.5 property base rates per admission or per day shall be derived from the best Medicare and  
523.6 claims data available when rates are established. The commissioner shall determine the best  
523.7 Medicare and claims data, taking into consideration variables of recency of the data, audit  
523.8 disposition, settlement status, and the ability to set rates in a timely manner. The  
523.9 commissioner shall notify hospitals of payment rates 30 days prior to implementation. The  
523.10 rate setting data must reflect the admissions data used to establish relative values. The  
523.11 commissioner may adjust base year cost, relative value, and case mix index data to exclude  
523.12 the costs of services that have been discontinued by October 1 of the year preceding the  
523.13 rate year or that are paid separately from inpatient services. Inpatient stays that encompass  
523.14 portions of two or more rate years shall have payments established based on payment rates  
523.15 in effect at the time of admission unless the date of admission preceded the rate year in  
523.16 effect by six months or more. In this case, operating payment rates for services rendered  
523.17 during the rate year in effect and established based on the date of admission shall be adjusted  
523.18 to the rate year in effect by the hospital cost index.

523.19 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment,  
523.20 before third-party liability and spenddown, made to hospitals for inpatient services is reduced  
523.21 by .5 percent from the current statutory rates.

523.22 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service  
523.23 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before  
523.24 third-party liability and spenddown, is reduced five percent from the current statutory rates.  
523.25 Mental health services within diagnosis related groups 424 to 432 or corresponding  
523.26 APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph.

523.27 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for  
523.28 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for  
523.29 inpatient services before third-party liability and spenddown, is reduced 6.0 percent from  
523.30 the current statutory rates. Mental health services within diagnosis related groups 424 to  
523.31 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded  
523.32 from this paragraph. Payments made to managed care plans shall be reduced for services  
523.33 provided on or after January 1, 2006, to reflect this reduction.

523.34 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for  
523.35 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made  
524.1 to hospitals for inpatient services before third-party liability and spenddown, is reduced  
524.2 3.46 percent from the current statutory rates. Mental health services with diagnosis related

524.3 groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision  
524.4 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced  
524.5 for services provided on or after January 1, 2009, through June 30, 2009, to reflect this  
524.6 reduction.

524.7 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for  
524.8 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made  
524.9 to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9  
524.10 percent from the current statutory rates. Mental health services with diagnosis related groups  
524.11 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are  
524.12 excluded from this paragraph. Payments made to managed care plans shall be reduced for  
524.13 services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

524.14 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for  
524.15 fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient  
524.16 services before third-party liability and spenddown, is reduced 1.79 percent from the current  
524.17 statutory rates. Mental health services with diagnosis related groups 424 to 432 or  
524.18 corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from  
524.19 this paragraph. Payments made to managed care plans shall be reduced for services provided  
524.20 on or after July 1, 2011, to reflect this reduction.

524.21 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment  
524.22 for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for  
524.23 inpatient services before third-party liability and spenddown, is reduced one percent from  
524.24 the current statutory rates. Facilities defined under subdivision 16 are excluded from this  
524.25 paragraph. Payments made to managed care plans shall be reduced for services provided  
524.26 on or after October 1, 2009, to reflect this reduction.

524.27 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment  
524.28 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for  
524.29 inpatient services before third-party liability and spenddown, is reduced 1.96 percent from  
524.30 the current statutory rates. Facilities defined under subdivision 16 are excluded from this  
524.31 paragraph. Payments made to managed care plans shall be reduced for services provided  
524.32 on or after January 1, 2011, to reflect this reduction.

524.33 (j) Effective for discharges on and after November 1, 2014, from hospitals paid under  
524.34 subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision  
525.1 must be incorporated into the rebased rates established under subdivision 2b, paragraph (c),  
525.2 and must not be applied to each claim.

525.3 (k) Effective for discharges on and after July 1, 2015, from hospitals paid under  
525.4 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision  
525.5 must be incorporated into the rates and must not be applied to each claim.

525.6 (l) Effective for discharges on and after July 1, 2017, from hospitals paid under  
525.7 subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be  
525.8 incorporated into the rates and must not be applied to each claim.

525.9 Sec. 12. Minnesota Statutes 2018, section 256.969, subdivision 9, is amended to read:

525.10 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions  
525.11 occurring on or after July 1, 1993, the medical assistance disproportionate population  
525.12 adjustment shall comply with federal law and shall be paid to a hospital, excluding regional  
525.13 treatment centers and facilities of the federal Indian Health Service, with a medical assistance  
525.14 inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined  
525.15 as follows:

525.16 (1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic  
525.17 mean for all hospitals excluding regional treatment centers and facilities of the federal Indian  
525.18 Health Service but less than or equal to one standard deviation above the mean, the  
525.19 adjustment must be determined by multiplying the total of the operating and property  
525.20 payment rates by the difference between the hospital's actual medical assistance inpatient  
525.21 utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers  
525.22 and facilities of the federal Indian Health Service; and

525.23 (2) for a hospital with a medical assistance inpatient utilization rate above one standard  
525.24 deviation above the mean, the adjustment must be determined by multiplying the adjustment  
525.25 that would be determined under clause (1) for that hospital by 1.1. The commissioner shall  
525.26 report annually on the number of hospitals likely to receive the adjustment authorized by  
525.27 this paragraph. The commissioner shall specifically report on the adjustments received by  
525.28 public hospitals and public hospital corporations located in cities of the first class.

525.29 (b) Certified public expenditures made by Hennepin County Medical Center shall be  
525.30 considered Medicaid disproportionate share hospital payments. Hennepin County and  
525.31 Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning  
525.32 July 1, 2005, or another date specified by the commissioner, that may qualify for  
526.1 reimbursement under federal law. Based on these reports, the commissioner shall apply for  
526.2 federal matching funds.

526.3 (c) Upon federal approval of the related state plan amendment, paragraph (b) is effective  
526.4 retroactively from July 1, 2005, or the earliest effective date approved by the Centers for  
526.5 Medicare and Medicaid Services.

526.6 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid  
526.7 in accordance with a new methodology using 2012 as the base year. Annual payments made  
526.8 under this paragraph shall equal the total amount of payments made for 2012. A licensed  
526.9 children's hospital shall receive only a single DSH factor for children's hospitals. Other  
526.10 DSH factors may be combined to arrive at a single factor for each hospital that is eligible  
526.11 for DSH payments. The new methodology shall make payments only to hospitals located  
526.12 in Minnesota and include the following factors:

526.13 (1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the  
 526.14 base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000  
 526.15 fee-for-service discharges in the base year shall receive a factor of 0.7880;

526.16 (2) a hospital that has in effect for the initial rate year a contract with the commissioner  
 526.17 to provide extended psychiatric inpatient services under section 256.9693 shall receive a  
 526.18 factor of 0.0160;

526.19 (3) a hospital that has received payment from the fee-for-service program for at least 20  
 526.20 transplant services in the base year shall receive a factor of 0.0435;

526.21 (4) a hospital that has a medical assistance utilization rate in the base year between 20  
 526.22 percent up to one standard deviation above the statewide mean utilization rate shall receive  
 526.23 a factor of 0.0468;

526.24 (5) a hospital that has a medical assistance utilization rate in the base year that is at least  
 526.25 one standard deviation above the statewide mean utilization rate but is less than three standard  
 526.26 deviations above the mean shall receive a factor of 0.2300; and

526.27 (6) a hospital that has a medical assistance utilization rate in the base year that is at least  
 526.28 three two and one-half standard deviations above the statewide mean utilization rate shall  
 526.29 receive a factor of 0.3711.

526.30 (e) Any payments or portion of payments made to a hospital under this subdivision that  
 526.31 are subsequently returned to the commissioner because the payments are found to exceed  
 526.32 the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the  
 526.33 number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that  
 527.1 have a medical assistance utilization rate that is at least one standard deviation above the  
 527.2 mean.

527.3 (f) An additional payment adjustment shall be established by the commissioner under  
 527.4 this subdivision for a hospital that provides high levels of administering high-cost drugs to  
 527.5 enrollees in fee-for-service medical assistance. The commissioner shall consider factors  
 527.6 including fee-for-service medical assistance utilization rates and payments made for drugs  
 527.7 purchased through the 340B drug purchasing program and administered to fee-for-service  
 527.8 enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate  
 527.9 share hospital limit, the commissioner shall make a payment to the hospital that equals the  
 527.10 nonfederal share of the amount that exceeds the limit. The total nonfederal share of the  
 527.11 amount of the payment adjustment under this paragraph shall not exceed \$1,500,000.

527.12 **EFFECTIVE DATE.** This section is effective July 1, 2019, except paragraph (f) is  
 527.13 effective for discharges on or after April 1, 2019.

527.14 Sec. 13. Minnesota Statutes 2018, section 256.969, subdivision 17, is amended to read:

527.15 Subd. 17. **Out-of-state hospitals in local trade areas.** Out-of-state hospitals that are  
 527.16 located within a Minnesota local trade area and that have ~~more than 20~~ admissions in the  
 527.17 base year or years shall have rates established using the same procedures and methods that



527.18 apply to Minnesota hospitals. For this subdivision and subdivision 18, local trade area means  
527.19 a county contiguous to Minnesota and located in a metropolitan statistical area as determined  
527.20 by Medicare for October 1 prior to the most current rebased rate year. Hospitals that are  
527.21 not required by law to file information in a format necessary to establish rates shall have  
527.22 rates established based on the commissioner's estimates of the information. Relative values  
527.23 of the diagnostic categories shall not be redetermined under this subdivision until required  
527.24 by statute. Hospitals affected by this subdivision shall then be included in determining  
527.25 relative values. However, hospitals that have rates established based upon the commissioner's  
527.26 estimates of information shall not be included in determining relative values. This subdivision  
527.27 is effective for hospital fiscal years beginning on or after July 1, 1988. A hospital shall  
527.28 provide the information necessary to establish rates under this subdivision at least 90 days  
527.29 before the start of the hospital's fiscal year.

527.30 Sec. 14. Minnesota Statutes 2018, section 256.969, subdivision 19, is amended to read:

527.31 Subd. 19. **Metabolic disorder testing of medical assistance recipients.** Medical  
527.32 assistance inpatient payment rates must include the cost incurred by hospitals to pay the  
527.33 Department of Health for metabolic disorder testing of newborns who are medical assistance  
528.1 recipients, if the cost is not recognized by another payment source. This payment increase  
528.2 remains in effect until the increase is fully recognized in the base year cost under subdivision  
528.3 2b.

528.4 Sec. 15. Minnesota Statutes 2018, section 256B.04, subdivision 14, is amended to read:

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

528.9 (1) eyeglasses;

ARTICLE 1:

19.31 Sec. 22. Minnesota Statutes 2018, section 256B.02, is amended by adding a subdivision  
19.32 to read:

19.33 Subd. 20. **Income.** Income is calculated using the adjusted gross income methodology  
19.34 under the Affordable Care Act. Income includes funds in personal or business accounts  
20.1 used to pay personal expenses including rent, mortgage, automobile-related expenses,  
20.2 utilities, food, and other personal expenses not directly related to the business, unless the  
20.3 funds are directly attributable to an exception to the income requirement specifically  
20.4 identified by the applicant.

ARTICLE 8:

270.1 Sec. 6. Minnesota Statutes 2018, section 256B.04, subdivision 14, is amended to read:

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

270.6 (1) eyeglasses;

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

528.13 (3) hearing aids and supplies; ~~and~~

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

528.15 (i) hospital beds;

528.16 (ii) commodes;

528.17 (iii) glide-about chairs;

528.18 (iv) patient lift apparatus;

528.19 (v) wheelchairs and accessories;

528.20 (vi) oxygen administration equipment;

528.21 (vii) respiratory therapy equipment;

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

528.23 (ix) allergen-reducing products as described in section 256B.0625, subdivision 66,  
528.24 paragraph (c);

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

528.28 (6) drugs.

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

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

529.3 Sec. 16. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

529.4 Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct  
529.5 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart  
529.6 E. A provider providing services from multiple locations must enroll each location separately.  
529.7 The commissioner may deny a provider's incomplete application if a provider fails to respond  
529.8 to the commissioner's request for additional information within 60 days of the request. The

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

270.10 (3) hearing aids and supplies; and

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

270.12 (i) hospital beds;

270.13 (ii) commodes;

270.14 (iii) glide-about chairs;

270.15 (iv) patient lift apparatus;

270.16 (v) wheelchairs and accessories;

270.17 (vi) oxygen administration equipment;

270.18 (vii) respiratory therapy equipment;

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

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

270.23 (6) drugs.

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

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

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

ARTICLE 1:

20.5 Sec. 23. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

20.6 Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct  
20.7 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart  
20.8 E, including database checks, unannounced pre- and post-enrollment site visits, fingerprinting,  
20.9 and criminal background studies. A provider providing services from multiple licensed  
20.10 locations must enroll each licensed location separately. The commissioner may deny a

529.9 commissioner must conduct a background study under chapter 245C, including a review  
 529.10 of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), for a provider  
 529.11 described in this paragraph. The background study requirement may be satisfied if the  
 529.12 commissioner conducted a fingerprint-based background study on the provider that includes  
 529.13 a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).

529.14 (b) The commissioner shall revalidate each: (1) provider under this subdivision at least  
 529.15 once every five years; and (2) personal care assistance agency under this subdivision once  
 529.16 every three years.

529.17 (c) The commissioner shall conduct revalidation as follows:

529.18 (1) provide 30-day notice of the revalidation due date including instructions for  
 529.19 revalidation and a list of materials the provider must submit;

529.20 (2) if a provider fails to submit all required materials by the due date, notify the provider  
 529.21 of the deficiency within 30 days after the due date and allow the provider an additional 30  
 529.22 days from the notification date to comply; and

529.23 (3) if a provider fails to remedy a deficiency within the 30-day time period, give 60-day  
 529.24 notice of termination and immediately suspend the provider's ability to bill. The provider  
 529.25 does not have the right to appeal suspension of ability to bill.

529.26 (d) If a provider fails to comply with any individual provider requirement or condition  
 529.27 of participation, the commissioner may suspend the provider's ability to bill until the provider  
 529.28 comes into compliance. The commissioner's decision to suspend the provider is not subject  
 529.29 to an administrative appeal.

529.30 (e) All correspondence and notifications, including notifications of termination and other  
 529.31 actions, must be delivered electronically to a provider's MN-ITS mailbox. For a provider  
 529.32 that does not have a MN-ITS account and mailbox, notice must be sent by first-class mail.  
 530.1 This paragraph does not apply to correspondences and notifications related to background  
 530.2 studies.

530.3 (f) If the commissioner or the Centers for Medicare and Medicaid Services determines  
 530.4 that a provider is designated "high-risk," the commissioner may withhold payment from  
 530.5 providers within that category upon initial enrollment for a 90-day period. The withholding  
 530.6 for each provider must begin on the date of the first submission of a claim.

20.11 provider's incomplete application for enrollment if a provider fails to respond to the  
 20.12 commissioner's request for additional information within 60 days of the request.

20.13 (b) The commissioner must revalidate each provider under this subdivision at least once  
 20.14 every five years. The commissioner may revalidate a personal care assistance agency under  
 20.15 this subdivision once every three years. The commissioner shall conduct revalidation as  
 20.16 follows:

20.17 (1) provide 30-day notice of revalidation due date to include instructions for revalidation  
 20.18 and a list of materials the provider must submit to revalidate;

20.19 (2) notify the provider that fails to completely respond within 30 days of any deficiencies  
 20.20 and allow an additional 30 days to comply; and

20.21 (3) give 60-day notice of termination and immediately suspend a provider's ability to  
 20.22 bill for failure to remedy any deficiencies within the 30-day time period. The commissioner's  
 20.23 decision to suspend the provider's ability to bill is not subject to an administrative appeal.

20.24 (c) The commissioner shall require that an individual rendering care to a recipient for  
 20.25 the following covered services enroll as an individual provider and be identified on claims:

20.26 (1) consumer directed community supports; and

20.27 (2) qualified professionals supervising personal care assistant services according to  
 20.28 section 256B.0659.

20.29 (d) The commissioner may suspend a provider's ability to bill for a failure to comply  
 20.30 with any individual provider requirements or conditions of participation until the provider  
 20.31 comes into compliance. The commissioner's decision to suspend the provider's ability to  
 20.32 bill is not subject to an administrative appeal.

21.1 (e) Notwithstanding any other provision to the contrary, all correspondence and  
 21.2 notifications, including notifications of termination and other actions, shall be delivered  
 21.3 electronically to a provider's MN-ITS mailbox. For a provider that does not have a MN-ITS  
 21.4 account and mailbox, notice shall be sent by first class mail.

21.5 (f) If the commissioner or the Centers for Medicare and Medicaid Services determines  
 21.6 that a provider is designated "high-risk," the commissioner may withhold payment from  
 21.7 providers within that category upon initial enrollment for a 90-day period. The withholding  
 21.8 for each provider must begin on the date of the first submission of a claim.

530.7 ~~(b)~~ (g) An enrolled provider that is also licensed by the commissioner under chapter  
 530.8 245A, or is licensed as a home care provider by the Department of Health under chapter  
 530.9 144A and has a home and community-based services designation on the home care license  
 530.10 under section 144A.484, must designate an individual as the entity's compliance officer.  
 530.11 The compliance officer must:

530.12 (1) develop policies and procedures to assure adherence to medical assistance laws and  
 530.13 regulations and to prevent inappropriate claims submissions;

530.14 (2) train the employees of the provider entity, and any agents or subcontractors of the  
 530.15 provider entity including billers, on the policies and procedures under clause (1);

530.16 (3) respond to allegations of improper conduct related to the provision or billing of  
 530.17 medical assistance services, and implement action to remediate any resulting problems;

530.18 (4) use evaluation techniques to monitor compliance with medical assistance laws and  
 530.19 regulations;

530.20 (5) promptly report to the commissioner any identified violations of medical assistance  
 530.21 laws or regulations; and

530.22 (6) within 60 days of discovery by the provider of a medical assistance reimbursement  
 530.23 overpayment, report the overpayment to the commissioner and make arrangements with  
 530.24 the commissioner for the commissioner's recovery of the overpayment.

530.25 The commissioner may require, as a condition of enrollment in medical assistance, that a  
 530.26 provider within a particular industry sector or category establish a compliance program that  
 530.27 contains the core elements established by the Centers for Medicare and Medicaid Services.

530.28 ~~(e)~~ (h) The commissioner may revoke the enrollment of an ordering or rendering provider  
 530.29 for a period of not more than one year, if the provider fails to maintain and, upon request  
 530.30 from the commissioner, provide access to documentation relating to written orders or requests  
 530.31 for payment for durable medical equipment, certifications for home health services, or  
 530.32 referrals for other items or services written or ordered by such provider, when the  
 530.33 commissioner has identified a pattern of a lack of documentation. A pattern means a failure  
 531.1 to maintain documentation or provide access to documentation on more than one occasion.  
 531.2 Nothing in this paragraph limits the authority of the commissioner to sanction a provider  
 531.3 under the provisions of section 256B.064.

531.4 ~~(d)~~ (i) The commissioner shall terminate or deny the enrollment of any individual or  
 531.5 entity if the individual or entity has been terminated from participation in Medicare or under  
 531.6 the Medicaid program or Children's Health Insurance Program of any other state.

531.7 ~~(e)~~ (j) As a condition of enrollment in medical assistance, the commissioner shall require  
 531.8 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and  
 531.9 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid  
 531.10 Services, its agents, or its designated contractors and the state agency, its agents, or its  
 531.11 designated contractors to conduct unannounced on-site inspections of any provider location.

21.9 ~~(b)~~ (g) An enrolled provider that is also licensed by the commissioner under chapter  
 21.10 245A, or is licensed as a home care provider by the Department of Health under chapter  
 21.11 144A and has a home and community-based services designation on the home care license  
 21.12 under section 144A.484, must designate an individual as the entity's compliance officer.  
 21.13 The compliance officer must:

21.14 (1) develop policies and procedures to assure adherence to medical assistance laws and  
 21.15 regulations and to prevent inappropriate claims submissions;

21.16 (2) train the employees of the provider entity, and any agents or subcontractors of the  
 21.17 provider entity including billers, on the policies and procedures under clause (1);

21.18 (3) respond to allegations of improper conduct related to the provision or billing of  
 21.19 medical assistance services, and implement action to remediate any resulting problems;

21.20 (4) use evaluation techniques to monitor compliance with medical assistance laws and  
 21.21 regulations;

21.22 (5) promptly report to the commissioner any identified violations of medical assistance  
 21.23 laws or regulations; and

21.24 (6) within 60 days of discovery by the provider of a medical assistance reimbursement  
 21.25 overpayment, report the overpayment to the commissioner and make arrangements with  
 21.26 the commissioner for the commissioner's recovery of the overpayment.

21.27 The commissioner may require, as a condition of enrollment in medical assistance, that a  
 21.28 provider within a particular industry sector or category establish a compliance program that  
 21.29 contains the core elements established by the Centers for Medicare and Medicaid Services.

21.30 ~~(e)~~ (h) The commissioner may revoke the enrollment of an ordering or rendering provider  
 21.31 for a period of not more than one year, if the provider fails to maintain and, upon request  
 21.32 from the commissioner, provide access to documentation relating to written orders or requests  
 21.33 for payment for durable medical equipment, certifications for home health services, or  
 22.1 referrals for other items or services written or ordered by such provider, when the  
 22.2 commissioner has identified a pattern of a lack of documentation. A pattern means a failure  
 22.3 to maintain documentation or provide access to documentation on more than one occasion.  
 22.4 Nothing in this paragraph limits the authority of the commissioner to sanction a provider  
 22.5 under the provisions of section 256B.064.

22.6 ~~(d)~~ (i) The commissioner shall terminate or deny the enrollment of any individual or  
 22.7 entity if the individual or entity has been terminated from participation in Medicare or under  
 22.8 the Medicaid program or Children's Health Insurance Program of any other state.

22.9 ~~(e)~~ (j) As a condition of enrollment in medical assistance, the commissioner shall require  
 22.10 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and  
 22.11 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid  
 22.12 Services, its agents, or its designated contractors and the state agency, its agents, or its  
 22.13 designated contractors to conduct unannounced on-site inspections of any provider location.

531.12 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a  
 531.13 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria  
 531.14 and standards used to designate Medicare providers in Code of Federal Regulations, title  
 531.15 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.  
 531.16 The commissioner's designations are not subject to administrative appeal.

531.17 ~~(g)~~ (k) As a condition of enrollment in medical assistance, the commissioner shall require  
 531.18 that a high-risk provider, or a person with a direct or indirect ownership interest in the  
 531.19 provider of five percent or higher, consent to criminal background checks, including  
 531.20 fingerprinting, when required to do so under state law or by a determination by the  
 531.21 commissioner or the Centers for Medicare and Medicaid Services that a provider is designated  
 531.22 high-risk for fraud, waste, or abuse.

531.23 ~~(g)~~ (l) (1) Upon initial enrollment, reenrollment, and notification of revalidation, all  
 531.24 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers  
 531.25 meeting the durable medical equipment provider and supplier definition in clause (3),  
 531.26 operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is  
 531.27 annually renewed and designates the Minnesota Department of Human Services as the  
 531.28 obligee, and must be submitted in a form approved by the commissioner. For purposes of  
 531.29 this clause, the following medical suppliers are not required to obtain a surety bond: a  
 531.30 federally qualified health center, a home health agency, the Indian Health Service, a  
 531.31 pharmacy, and a rural health clinic.

531.32 (2) At the time of initial enrollment or reenrollment, durable medical equipment providers  
 531.33 and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating  
 531.34 provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,  
 532.1 the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's  
 532.2 Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must  
 532.3 purchase a surety bond of \$100,000. The surety bond must allow for recovery of costs and  
 532.4 fees in pursuing a claim on the bond.

532.5 (3) "Durable medical equipment provider or supplier" means a medical supplier that can  
 532.6 purchase medical equipment or supplies for sale or rental to the general public and is able  
 532.7 to perform or arrange for necessary repairs to and maintenance of equipment offered for  
 532.8 sale or rental.

532.9 ~~(h)~~ (m) The Department of Human Services may require a provider to purchase a surety  
 532.10 bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment  
 532.11 if: (1) the provider fails to demonstrate financial viability, (2) the department determines  
 532.12 there is significant evidence of or potential for fraud and abuse by the provider, or (3) the  
 532.13 provider or category of providers is designated high-risk pursuant to paragraph ~~(a)~~ (f) and  
 532.14 as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in  
 532.15 an amount of \$100,000 or ten percent of the provider's payments from Medicaid during the  
 532.16 immediately preceding 12 months, whichever is greater. The surety bond must name the  
 532.17 Department of Human Services as an obligee and must allow for recovery of costs and fees

22.14 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a  
 22.15 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria  
 22.16 and standards used to designate Medicare providers in Code of Federal Regulations, title  
 22.17 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.  
 22.18 The commissioner's designations are not subject to administrative appeal.

22.19 ~~(g)~~ (k) As a condition of enrollment in medical assistance, the commissioner shall require  
 22.20 that a high-risk provider, or a person with a direct or indirect ownership interest in the  
 22.21 provider of five percent or higher, consent to criminal background checks, including  
 22.22 fingerprinting, when required to do so under state law or by a determination by the  
 22.23 commissioner or the Centers for Medicare and Medicaid Services that a provider is designated  
 22.24 high-risk for fraud, waste, or abuse.

22.25 ~~(g)~~ (l) (1) Upon initial enrollment, reenrollment, and notification of revalidation, all  
 22.26 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers  
 22.27 meeting the durable medical equipment provider and supplier definition in clause (3),  
 22.28 operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is  
 22.29 annually renewed and designates the Minnesota Department of Human Services as the  
 22.30 obligee, and must be submitted in a form approved by the commissioner. For purposes of  
 22.31 this clause, the following medical suppliers are not required to obtain a surety bond: a  
 22.32 federally qualified health center, a home health agency, the Indian Health Service, a  
 22.33 pharmacy, and a rural health clinic.

23.1 (2) At the time of initial enrollment or reenrollment, durable medical equipment providers  
 23.2 and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating  
 23.3 provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,  
 23.4 the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's  
 23.5 Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must  
 23.6 purchase a surety bond of \$100,000. The surety bond must be in a form approved by the  
 23.7 commissioner, renewed annually, and must allow for recovery of costs and fees in pursuing  
 23.8 a claim on the bond.

23.9 (3) "Durable medical equipment provider or supplier" means a medical supplier that can  
 23.10 purchase medical equipment or supplies for sale or rental to the general public and is able  
 23.11 to perform or arrange for necessary repairs to and maintenance of equipment offered for  
 23.12 sale or rental.

23.13 ~~(h)~~ (m) The Department of Human Services may require a provider to purchase a surety  
 23.14 bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment  
 23.15 if: (1) the provider fails to demonstrate financial viability, (2) the department determines  
 23.16 there is significant evidence of or potential for fraud and abuse by the provider, or (3) the  
 23.17 provider or category of providers is designated high-risk pursuant to paragraph ~~(a)~~ (e) and  
 23.18 as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in  
 23.19 an amount of \$100,000 or ten percent of the provider's payments from Medicaid during the  
 23.20 immediately preceding 12 months, whichever is greater. The surety bond must name the  
 23.21 Department of Human Services as an obligee and must allow for recovery of costs and fees

532.18 in pursuing a claim on the bond. This paragraph does not apply if the provider currently  
532.19 maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

532.20 **EFFECTIVE DATE.** This section is effective July 1, 2019.

532.21 Sec. 17. Minnesota Statutes 2018, section 256B.04, subdivision 22, is amended to read:

532.22 Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally  
532.23 required nonrefundable application fees to pay for provider screening activities in accordance  
532.24 with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application  
532.25 must be made under the procedures specified by the commissioner, in the form specified  
532.26 by the commissioner, and accompanied by an application fee described in paragraph (b),  
532.27 or a request for a hardship exception as described in the specified procedures. Application  
532.28 fees must be deposited in the provider screening account in the special revenue fund.  
532.29 Amounts in the provider screening account are appropriated to the commissioner for costs  
532.30 associated with the provider screening activities required in Code of Federal Regulations,  
532.31 title 42, section 455, subpart E. ~~The commissioner shall conduct screening activities as~~  
532.32 ~~required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise~~  
532.33 ~~provided by law, to include database checks, unannounced pre- and postenrollment site~~  
533.1 ~~visits, fingerprinting, and criminal background studies. The commissioner must revalidate~~  
533.2 ~~all providers under this subdivision at least once every five years.~~

533.3 (b) The application fee under this subdivision is \$532 for the calendar year 2013. For  
533.4 calendar year 2014 and subsequent years, the fee:

533.5 (1) is adjusted by the percentage change to the Consumer Price Index for all urban  
533.6 consumers, United States city average, for the 12-month period ending with June of the  
533.7 previous year. The resulting fee must be announced in the Federal Register;

533.8 (2) is effective from January 1 to December 31 of a calendar year;

533.9 (3) is required on the submission of an initial application, an application to establish a  
533.10 new practice location, an application for reenrollment when the provider is not enrolled at  
533.11 the time of application of reenrollment, or at revalidation when required by federal regulation;  
533.12 and

533.13 (4) must be in the amount in effect for the calendar year during which the application  
533.14 for enrollment, new practice location, or reenrollment is being submitted.

533.15 (c) The application fee under this subdivision cannot be charged to:

533.16 (1) providers who are enrolled in Medicare or who provide documentation of payment  
533.17 of the fee to, and enrollment with, another state, unless the commissioner is required to  
533.18 rescreen the provider;

533.19 (2) providers who are enrolled but are required to submit new applications for purposes  
533.20 of reenrollment;

23.22 in pursuing a claim on the bond. This paragraph does not apply if the provider currently  
23.23 maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

23.24 **EFFECTIVE DATE.** This section is effective July 1, 2019, with the exception that the  
23.25 amendments to paragraph (1), clause (2), are effective January 1, 2020.

533.21 (3) a provider who enrolls as an individual; and

533.22 (4) group practices and clinics that bill on behalf of individually enrolled providers

533.23 within the practice who have reassigned their billing privileges to the group practice or

533.24 clinic.

533.25 **EFFECTIVE DATE.** This section is effective July 1, 2019.

533.26 Sec. 18. Minnesota Statutes 2018, section 256B.055, subdivision 2, is amended to read:

533.27 Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible

533.28 for or receiving foster care maintenance payments under Title IV-E of the Social Security

533.29 Act, United States Code, title 42, sections 670 to 676, and for a child who is not eligible for

533.30 Title IV-E of the Social Security Act but who is determined eligible for foster care or kinship

533.31 assistance under chapter 256N.

534.1 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,

534.2 whichever is later. The commissioner of human services shall notify the revisor of statutes

534.3 when federal approval is obtained.

534.4 Sec. 19. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

534.5 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical

534.6 assistance, a person must not individually own more than \$3,000 in assets, or if a member

534.7 of a household with two family members, husband and wife, or parent and child, the

534.8 household must not own more than \$6,000 in assets, plus \$200 for each additional legal

534.9 dependent. In addition to these maximum amounts, an eligible individual or family may

534.10 accrue interest on these amounts, but they must be reduced to the maximum at the time of

ARTICLE 8:

271.1 Sec. 7. Minnesota Statutes 2018, section 256B.056, subdivision 1, is amended to read:

271.2 Subdivision 1. **Residency.** (a) To be eligible for medical assistance, a person must reside

271.3 in Minnesota, or, if absent from the state, be deemed to be a resident of Minnesota, in

271.4 accordance with Code of Federal Regulations, title 42, section 435.403.

271.5 (b) The commissioner shall identify individuals who are enrolled in medical assistance

271.6 and who are absent from the state for more than 30 consecutive days, but who continue to

271.7 qualify for medical assistance in accordance with paragraph (a).

271.8 (c) If the individual is absent from the state for more than 30 consecutive days but still

271.9 deemed a resident of Minnesota in accordance with paragraph (a), any covered service

271.10 provided to the individual must be paid through the fee-for-service system and not through

271.11 the managed care capitated rate payment system under section 256B.69 or 256L.12.

ARTICLE 1:

23.26 Sec. 24. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

23.27 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical

23.28 assistance, a person must not individually own more than \$3,000 in assets, or if a member

23.29 of a household with two family members, husband and wife, or parent and child, the

23.30 household must not own more than \$6,000 in assets, plus \$200 for each additional legal

23.31 dependent. In addition to these maximum amounts, an eligible individual or family may

23.32 accrue interest on these amounts, but they must be reduced to the maximum at the time of



534.11 an eligibility redetermination. The accumulation of the clothing and personal needs allowance  
534.12 according to section 256B.35 must also be reduced to the maximum at the time of the  
534.13 eligibility redetermination. The value of assets that are not considered in determining  
534.14 eligibility for medical assistance is the value of those assets excluded under the Supplemental  
534.15 Security Income program for aged, blind, and disabled persons, with the following  
534.16 exceptions:

534.17 (1) household goods and personal effects are not considered;

534.18 (2) capital and operating assets of a trade or business that the local agency determines  
534.19 are necessary to the person's ability to earn an income are not considered;

23.33 an eligibility redetermination. The accumulation of the clothing and personal needs allowance  
23.34 according to section 256B.35 must also be reduced to the maximum at the time of the  
24.1 eligibility redetermination. The value of assets that are not considered in determining  
24.2 eligibility for medical assistance is the value of those assets excluded under the Supplemental  
24.3 Security Income program for aged, blind, and disabled persons, with the following  
24.4 exceptions:

24.5 (1) household goods and personal effects are not considered;

24.6 (2) capital and operating assets of a trade or business that the local agency determines  
24.7 are necessary to the person's ability to earn an income are not considered. A bank account  
24.8 that contains personal income or assets or is used to pay personal expenses is not a capital  
24.9 or operating asset of a trade or business;

24.10 (3) motor vehicles are excluded to the same extent excluded by the Supplemental Security  
24.11 Income program;

24.12 (4) assets designated as burial expenses are excluded to the same extent excluded by the  
24.13 Supplemental Security Income program. Burial expenses funded by annuity contracts or  
24.14 life insurance policies must irrevocably designate the individual's estate as contingent  
24.15 beneficiary to the extent proceeds are not used for payment of selected burial expenses;

24.16 (5) for a person who no longer qualifies as an employed person with a disability due to  
24.17 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,  
24.18 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility  
24.19 as an employed person with a disability, to the extent that the person's total assets remain  
24.20 within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

24.21 (6) when a person enrolled in medical assistance under section 256B.057, subdivision  
24.22 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before  
24.23 the person's 65th birthday, the assets owned by the person and the person's spouse must be  
24.24 disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when  
24.25 determining eligibility for medical assistance under section 256B.055, subdivision 7. The  
24.26 income of a spouse of a person enrolled in medical assistance under section 256B.057,  
24.27 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday  
24.28 must be disregarded when determining eligibility for medical assistance under section  
24.29 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions  
24.30 in section 256B.059; and

24.31 (7) effective July 1, 2009, certain assets owned by American Indians are excluded as  
24.32 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public  
24.33 Law 111-5. For purposes of this clause, an American Indian is any person who meets the  
24.34 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

25.1 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision  
25.2 15.

ARTICLE 8:

534.20       (3) motor vehicles are excluded to the same extent excluded by the Supplemental Security  
534.21 Income program;

534.22       (4) assets designated as burial expenses are excluded to the same extent excluded by the  
534.23 Supplemental Security Income program. Burial expenses funded by annuity contracts or  
534.24 life insurance policies must irrevocably designate the individual's estate as contingent  
534.25 beneficiary to the extent proceeds are not used for payment of selected burial expenses;

534.26       (5) for a person who no longer qualifies as an employed person with a disability due to  
534.27 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,  
534.28 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility  
534.29 as an employed person with a disability, to the extent that the person's total assets remain  
534.30 within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

534.31       (6) when a person enrolled in medical assistance under section 256B.057, subdivision  
534.32 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before  
534.33 the person's 65th birthday, the assets owned by the person and the person's spouse must be  
535.1 disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when  
535.2 determining eligibility for medical assistance under section 256B.055, subdivision 7; a  
535.3 designated employment incentives asset account is disregarded when determining eligibility  
535.4 for medical assistance for a person age 65 years or older under section 256B.055, subdivision  
535.5 7. An employment incentives asset account must only be designated by a person who has  
535.6 been enrolled in medical assistance under section 256B.057, subdivision 9, for a  
535.7 24-consecutive-month period. A designated employment incentives asset account contains  
535.8 qualified assets owned by the person and the person's spouse in the last month of enrollment

271.12       Sec. 8. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

271.13       Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical  
271.14 assistance, a person must not individually own more than \$3,000 in assets, or if a member  
271.15 of a household with two family members, husband and wife, or parent and child, the  
271.16 household must not own more than \$6,000 in assets, plus \$200 for each additional legal  
271.17 dependent. In addition to these maximum amounts, an eligible individual or family may  
271.18 accrue interest on these amounts, but they must be reduced to the maximum at the time of  
271.19 an eligibility redetermination. The accumulation of the clothing and personal needs allowance  
271.20 according to section 256B.35 must also be reduced to the maximum at the time of the  
271.21 eligibility redetermination. The value of assets that are not considered in determining  
271.22 eligibility for medical assistance is the value of those assets excluded under the Supplemental  
271.23 Security Income program for aged, blind, and disabled persons, with the following  
271.24 exceptions:

271.25       (1) household goods and personal effects are not considered;

271.26       (2) capital and operating assets of a trade or business that the local agency determines  
271.27 are necessary to the person's ability to earn an income are not considered;

271.28       (3) motor vehicles are excluded to the same extent excluded by the Supplemental Security  
271.29 Income program;

271.30       (4) assets designated as burial expenses are excluded to the same extent excluded by the  
271.31 Supplemental Security Income program. Burial expenses funded by annuity contracts or  
271.32 life insurance policies must irrevocably designate the individual's estate as contingent  
271.33 beneficiary to the extent proceeds are not used for payment of selected burial expenses;

272.1       (5) for a person who no longer qualifies as an employed person with a disability due to  
272.2 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,  
272.3 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility  
272.4 as an employed person with a disability, to the extent that the person's total assets remain  
272.5 within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

272.6       (6) when a person enrolled in medical assistance under section 256B.057, subdivision  
272.7 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before  
272.8 the person's 65th birthday, the assets owned by the person and the person's spouse must be  
272.9 disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when  
272.10 determining eligibility for medical assistance under section 256B.055, subdivision 7; a  
272.11 designated employment incentives asset account is disregarded when determining eligibility  
272.12 for medical assistance for a person age 65 years or older under section 256B.055, subdivision  
272.13 7. An employment incentives asset account must only be designated by a person who has  
272.14 been enrolled in medical assistance under section 256B.057, subdivision 9, for a  
272.15 24-consecutive-month period. A designated employment incentives asset account contains  
272.16 qualified assets owned by the person and the person's spouse in the last month of enrollment

535.9 in medical assistance under section 256B.057, subdivision 9. Qualified assets include  
535.10 retirement and pension accounts, medical expense accounts, and up to \$17,000 of the person's  
535.11 other nonexcluded assets. An employment incentives asset account is no longer designated  
535.12 when a person loses medical assistance eligibility for a calendar month or more before  
535.13 turning age 65. A person who loses medical assistance eligibility before age 65 can establish  
535.14 a new designated employment incentives asset account by establishing a new  
535.15 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The  
535.16 income of a spouse of a person enrolled in medical assistance under section 256B.057,  
535.17 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday  
535.18 must be disregarded when determining eligibility for medical assistance under section  
535.19 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions  
535.20 in section 256B.059; and

535.21 (7) effective July 1, 2009, certain assets owned by American Indians are excluded as  
535.22 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public  
535.23 Law 111-5. For purposes of this clause, an American Indian is any person who meets the  
535.24 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

535.25 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision  
535.26 15.

535.27 **EFFECTIVE DATE.** This section is effective July 1, 2019.

272.17 in medical assistance under section 256B.057, subdivision 9. Qualified assets include  
272.18 retirement and pension accounts, medical expense accounts, and up to \$17,000 of the person's  
272.19 other nonexcluded assets. An employment incentives asset account is no longer designated  
272.20 when a person loses medical assistance eligibility for a calendar month or more before  
272.21 turning age 65. A person who loses medical assistance eligibility before age 65 can establish  
272.22 a new designated employment incentives asset account by establishing a new  
272.23 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The  
272.24 income of a spouse of a person enrolled in medical assistance under section 256B.057,  
272.25 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday  
272.26 must be disregarded when determining eligibility for medical assistance under section  
272.27 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions  
272.28 in section 256B.059; and

272.29 (7) effective July 1, 2009, certain assets owned by American Indians are excluded as  
272.30 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public  
272.31 Law 111-5. For purposes of this clause, an American Indian is any person who meets the  
272.32 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

272.33 (b) Upon initial enrollment, no asset limit shall apply to persons eligible under section  
272.34 256B.055, subdivision 15. Upon renewal, a person eligible under section 256B.055,  
273.1 subdivision 15, must not own either individually or as a member of a household more than  
273.2 \$1,000,000 in assets to continue to be eligible for medical assistance.

273.3 **EFFECTIVE DATE.** Paragraph (a) is effective July 1, 2019. Paragraph (b) is effective  
273.4 upon federal approval.

ARTICLE 1:

25.3 Sec. 25. Minnesota Statutes 2018, section 256B.056, subdivision 4, is amended to read:

25.4 Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section  
25.5 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal  
25.6 poverty guidelines. Effective January 1, 2000, and each successive January, recipients of  
25.7 Supplemental Security Income may have an income up to the Supplemental Security Income  
25.8 standard in effect on that date.

25.9 (b) Effective January 1, 2014, to be eligible for medical assistance, under section  
25.10 256B.055, subdivision 3a, a parent or caretaker relative may have an income up to 133  
25.11 percent of the federal poverty guidelines for the household size.

25.12 (c) To be eligible for medical assistance under section 256B.055, subdivision 15, a  
25.13 person may have an income up to 133 percent of federal poverty guidelines for the household  
25.14 size.

25.15 (d) To be eligible for medical assistance under section 256B.055, subdivision 16, a child  
25.16 age 19 to 20 may have an income up to 133 percent of the federal poverty guidelines for  
25.17 the household size.

535.28 Sec. 20. Minnesota Statutes 2018, section 256B.056, subdivision 5c, is amended to read:

535.29 Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and

535.30 caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard

535.31 specified in subdivision 4, paragraph (b).

535.32 (b) The excess income standard for a person whose eligibility is based on blindness,

535.33 disability, or age of 65 or more years shall equal:

536.1 (1) 81 percent of the federal poverty guidelines; and

536.2 (2) 83 percent of the federal poverty guidelines, effective July 1, 2021.

25.18 (e) To be eligible for medical assistance under section 256B.055, subdivision 3a, a child

25.19 under age 19 may have income up to 275 percent of the federal poverty guidelines for the

25.20 household size or an equivalent standard when converted using modified adjusted gross

25.21 income methodology as required under the Affordable Care Act. Children who are enrolled

25.22 in medical assistance as of December 31, 2013, and are determined ineligible for medical

25.23 assistance because of the elimination of income disregards under modified adjusted gross

25.24 income methodology as defined in subdivision 1a remain eligible for medical assistance

25.25 under the Children's Health Insurance Program Reauthorization Act of 2009, Public Law

25.26 111-3, until the date of their next regularly scheduled eligibility redetermination as required

25.27 in subdivision 7a.

25.28 (f) In computing income to determine eligibility of persons under paragraphs (a) to (e)

25.29 who are not residents of long-term care facilities, the commissioner shall: (1) disregard

25.30 increases in income as required by Public Laws 94-566, section 503; 99-272; and 99-509.

25.31 For persons eligible under paragraph (a), veteran aid and attendance benefits and Veterans

25.32 Administration unusual medical expense payments are considered income to the recipient;

25.33 and (2) include all assets available to the applicant that are considered income according to

26.1 the Internal Revenue Service. Income includes all deposits into accounts owned or controlled

26.2 by the applicant, including amounts spent on personal expenses, including rent, mortgage,

26.3 automobile-related expenses, utilities, and food and amounts received as salary or draws

26.4 from business accounts and not otherwise excluded by federal or state laws. Income does

26.5 not include a deposit specifically identified by the applicant as a loan or gift, for which the

26.6 applicant provides the source, date, amount, and repayment terms.

ARTICLE 8:

273.5 Sec. 9. Minnesota Statutes 2018, section 256B.056, subdivision 5c, is amended to read:

273.6 Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and

273.7 caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard

273.8 specified in subdivision 4, paragraph (b).

273.9 (b) The excess income standard for a person whose eligibility is based on blindness,

273.10 disability, or age of 65 or more years shall equal ~~81~~ 82 percent of the federal poverty

273.11 guidelines. Effective July 1, 2021, the excess income standard for a person whose eligibility

273.12 is based on blindness disability, or age of 65 or more years, is the standard specified in

273.13 subdivision 4, paragraph (a).

273.14 **EFFECTIVE DATE.** This section is effective January 1, 2020.

ARTICLE 1:

26.7 Sec. 26. Minnesota Statutes 2018, section 256B.056, subdivision 7a, is amended to read:

26.8 Subd. 7a. **Periodic renewal of eligibility.** (a) The commissioner shall make an annual

26.9 redetermination of eligibility ~~based on information contained in the enrollee's case file and~~

26.10 ~~other information available to the agency, including but not limited to information accessed~~

26.11 through an electronic database, without requiring the enrollee to submit any information  
26.12 when sufficient data is available for the agency to renew eligibility.

26.13 (b) If the commissioner cannot renew eligibility in accordance with paragraph (a), The  
26.14 commissioner must provide the enrollee with a prepopulated renewal form containing  
26.15 eligibility information available to the agency and permit the enrollee to must submit the  
26.16 form with any corrections or additional information to the agency and sign the renewal form  
26.17 via any of the modes of submission specified in section 256B.04, subdivision 18.

26.18 (c) An enrollee who is terminated for failure to complete the renewal process may  
26.19 subsequently submit the renewal form and required information within four months after  
26.20 the date of termination and have coverage reinstated without a lapse, if otherwise eligible  
26.21 under this chapter.

26.22 (d) Notwithstanding paragraph (a), individuals eligible under subdivision 5 shall be  
26.23 required to renew eligibility every six months.

ARTICLE 8:

273.15 Sec. 10. Minnesota Statutes 2018, section 256B.056, subdivision 7a, is amended to read:

273.16 Subd. 7a. **Periodic renewal of eligibility.** (a) The commissioner shall make an annual  
273.17 redetermination of eligibility based on information contained in the enrollee's case file and  
273.18 other information available to the agency, including but not limited to information accessed  
273.19 through an electronic database, without requiring the enrollee to submit any information  
273.20 when sufficient data is available for the agency to renew eligibility.

273.21 (b) If the commissioner cannot renew eligibility in accordance with paragraph (a), the  
273.22 commissioner must provide the enrollee with a prepopulated renewal form containing  
273.23 eligibility information available to the agency and permit the enrollee to submit the form  
273.24 with any corrections or additional information to the agency and sign the renewal form via  
273.25 any of the modes of submission specified in section 256B.04, subdivision 18.

273.26 (c) An enrollee who is terminated for failure to complete the renewal process may  
273.27 subsequently submit the renewal form and required information within four months after  
273.28 the date of termination and have coverage reinstated without a lapse, if otherwise eligible  
273.29 under this chapter. The local agency may close the enrollee's case file if the required  
273.30 information is not submitted within four months of termination.

273.31 (d) Notwithstanding paragraph (a), individuals eligible under subdivision 5 shall be  
273.32 required to renew eligibility every six months.

536.3 Sec. 21. Minnesota Statutes 2018, section 256B.0625, subdivision 3b, is amended to read:

536.4 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary  
536.5 services and consultations delivered by a licensed health care provider via telemedicine in  
536.6 the same manner as if the service or consultation was delivered in person. Coverage is

536.7 limited to three telemedicine services per enrollee per calendar week, except as provided  
536.8 in paragraph (f). Telemedicine services shall be paid at the full allowable rate.

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

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

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

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

536.18 (4) has established protocols addressing how and when to discontinue telemedicine  
536.19 services; and

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

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

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

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

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

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

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

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

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

537.7 (d) For purposes of this subdivision, unless otherwise covered under this chapter,  
537.8 "telemedicine" is defined as the delivery of health care services or consultations while the  
537.9 patient is at an originating site and the licensed health care provider is at a distant site. A  
537.10 communication between licensed health care providers, or a licensed health care provider

537.11 and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission  
537.12 does not constitute telemedicine consultations or services. Telemedicine may be provided  
537.13 by means of real-time two-way, interactive audio and visual communications, including the  
537.14 application of secure video conferencing or store-and-forward technology to provide or  
537.15 support health care delivery, which facilitate the assessment, diagnosis, consultation,  
537.16 treatment, education, and care management of a patient's health care.

537.17 (e) For purposes of this section, "licensed health care provider" means a licensed health  
537.18 care provider under section 62A.671, subdivision 6, and a mental health practitioner defined  
537.19 under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the  
537.20 general supervision of a mental health professional; "health care provider" is defined under  
537.21 section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671,  
537.22 subdivision 7.

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

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

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

537.30 Sec. 22. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision  
537.31 to read:

537.32 Subd. 5m. **Conversion therapy.** Conversion therapy, as defined in section 214.078, is  
537.33 not covered.

538.1 Sec. 23. Minnesota Statutes 2018, section 256B.0625, subdivision 9, is amended to read:

538.2 Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

538.3 (b) Medical assistance dental coverage for ~~nonpregnant~~ adults is limited to the following  
538.4 services:

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

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

538.7 (3) limited exams;

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

538.9 (5) periapical x-rays;

538.10 (6) panoramic x-rays, limited to one every five years except (1) when medically necessary  
538.11 for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once

274.1 Sec. 11. Minnesota Statutes 2018, section 256B.0625, subdivision 9, is amended to read:

274.2 Subd. 9. **Dental services.** (a) Medical assistance covers dental services in accordance  
274.3 with this subdivision.

274.4 (b) Medical assistance dental coverage for ~~nonpregnant adults~~ adults who are eligible  
274.5 under section 256B.055, subdivision 7, is limited to the following services:

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

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

274.8 (3) limited exams;

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

274.10 (5) periapical x-rays;

274.11 (6) panoramic x-rays, limited to one every five years except (1) when medically necessary  
274.12 for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once



538.12 every two years for patients who cannot cooperate for intraoral film due to a developmental  
538.13 disability or medical condition that does not allow for intraoral film placement;

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

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

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

538.17 (10) anterior fillings;

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

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

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

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

538.22 (15) full-mouth debridement, limited to one every five years; ~~and~~

538.23 (16) nonsurgical treatment for periodontal disease, including scaling and root planing  
538.24 once every two years for each quadrant, and routine periodontal maintenance procedures.

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

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

538.29 (2) general anesthesia; and

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

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

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

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

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

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

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

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

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

274.13 every two years for patients who cannot cooperate for intraoral film due to a developmental  
274.14 disability or medical condition that does not allow for intraoral film placement;

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

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

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

274.18 (10) anterior fillings;

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

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

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

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

274.23 (15) full-mouth debridement, limited to one every five years;

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

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

274.28 (2) general anesthesia; and

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

275.1 ~~(e)~~ (a) Medical assistance covers medically necessary dental services for children and  
275.2 pregnant women. The following guidelines apply:

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

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

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

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

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

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

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

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

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

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

539.23 Sec. 24. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to read:

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

539.30 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,  
 539.31 unless authorized by the commissioner.

540.1 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical  
 540.2 ingredient" is defined as a substance that is represented for use in a drug and when used in  
 540.3 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the  
 540.4 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle  
 540.5 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and  
 540.6 excipients which are included in the medical assistance formulary. Medical assistance covers  
 540.7 selected active pharmaceutical ingredients and excipients used in compounded prescriptions  
 540.8 when the compounded combination is specifically approved by the commissioner or when  
 540.9 a commercially available product:

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

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

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

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

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

275.22 Sec. 12. Minnesota Statutes 2018, section 256B.0625, subdivision 12, is amended to read:

275.23 Subd. 12. **Eyeglasses, dentures, and prosthetic devices.** (a) Medical assistance covers  
 275.24 ~~eyeglasses, dentures, and~~ prosthetic devices if prescribed by a licensed practitioner.

275.25 (b) Medical assistance covers vision services, eyeglasses, and dentures for children,  
 275.26 pregnant women, and adults eligible under section 256B.055, subdivision 7, if prescribed  
 275.27 by a licensed practitioner.

275.28 Sec. 13. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to read:

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

276.5 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,  
 276.6 unless authorized by the commissioner.

276.7 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical  
 276.8 ingredient" is defined as a substance that is represented for use in a drug and when used in  
 276.9 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the  
 276.10 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle  
 276.11 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and  
 276.12 excipients which are included in the medical assistance formulary. Medical assistance covers  
 276.13 selected active pharmaceutical ingredients and excipients used in compounded prescriptions  
 276.14 when the compounded combination is specifically approved by the commissioner or when  
 276.15 a commercially available product:

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

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

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

540.15 (d) Medical assistance covers the following over-the-counter drugs when prescribed by  
540.16 a licensed practitioner or by a licensed pharmacist who meets standards established by the  
540.17 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family  
540.18 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults  
540.19 with documented vitamin deficiencies, vitamins for children under the age of seven and  
540.20 pregnant or nursing women, and any other over-the-counter drug identified by the  
540.21 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,  
540.22 and cost-effective for the treatment of certain specified chronic diseases, conditions, or  
540.23 disorders, and this determination shall not be subject to the requirements of chapter 14. A  
540.24 pharmacist may prescribe over-the-counter medications as provided under this paragraph  
540.25 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter  
540.26 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine  
540.27 necessity, provide drug counseling, review drug therapy for potential adverse interactions,  
540.28 and make referrals as needed to other health care professionals. ~~Over-the-counter medications~~  
540.29 ~~must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained~~  
540.30 ~~in the manufacturer's original package; (2) the number of dosage units required to complete~~  
540.31 ~~the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed~~  
540.32 ~~from a system using retrospective billing, as provided under subdivision 13c, paragraph~~  
540.33 ~~(b).~~

541.1 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable  
541.2 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and  
541.3 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible  
541.4 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and  
541.5 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these  
541.6 individuals, medical assistance may cover drugs from the drug classes listed in United States  
541.7 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to  
541.8 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall  
541.9 not be covered.

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

541.14 **EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval,  
541.15 whichever is later. The commissioner of human services shall notify the revisor of statutes  
541.16 when federal approval is obtained.

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

276.21 (d) Medical assistance covers the following over-the-counter drugs when prescribed by  
276.22 a licensed practitioner or by a licensed pharmacist who meets standards established by the  
276.23 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family  
276.24 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults  
276.25 with documented vitamin deficiencies, vitamins for children under the age of seven and  
276.26 pregnant or nursing women, and any other over-the-counter drug identified by the  
276.27 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,  
276.28 and cost-effective for the treatment of certain specified chronic diseases, conditions, or  
276.29 disorders, and this determination shall not be subject to the requirements of chapter 14. A  
276.30 pharmacist may prescribe over-the-counter medications as provided under this paragraph  
276.31 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter  
276.32 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine  
276.33 necessity, provide drug counseling, review drug therapy for potential adverse interactions,  
276.34 and make referrals as needed to other health care professionals. ~~Over-the-counter medications~~  
277.1 ~~must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained~~  
277.2 ~~in the manufacturer's original package; (2) the number of dosage units required to complete~~  
277.3 ~~the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed~~  
277.4 ~~from a system using retrospective billing, as provided under subdivision 13c, paragraph~~  
277.5 ~~(b).~~

277.6 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable  
277.7 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and  
277.8 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible  
277.9 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and  
277.10 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these  
277.11 individuals, medical assistance may cover drugs from the drug classes listed in United States  
277.12 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to  
277.13 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall  
277.14 not be covered.

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

277.19 **EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval,  
277.20 whichever is later. The commissioner of human services shall notify the revisor of statutes  
277.21 when federal approval is obtained.

541.17 Sec. 25. Minnesota Statutes 2018, section 256B.0625, subdivision 13d, is amended to  
541.18 read:

541.19 Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its  
541.20 establishment and publication shall not be subject to the requirements of the Administrative  
541.21 Procedure Act, but the Formulary Committee shall review and comment on the formulary  
541.22 contents.

541.23 (b) The formulary shall not include:

541.24 (1) drugs, active pharmaceutical ingredients, or products for which there is no federal  
541.25 funding;

541.26 (2) over-the-counter drugs, except as provided in subdivision 13;

541.27 ~~(3) drugs or active pharmaceutical ingredients used for weight loss, except that medically~~  
541.28 ~~necessary lipase inhibitors may be covered for a recipient with type II diabetes;~~

541.29 ~~(4)~~ (3) drugs or active pharmaceutical ingredients when used for the treatment of  
541.30 impotence or erectile dysfunction;

541.31 ~~(5)~~ (4) drugs or active pharmaceutical ingredients for which medical value has not been  
541.32 established;

542.1 ~~(6)~~ (5) drugs from manufacturers who have not signed a rebate agreement with the  
542.2 Department of Health and Human Services pursuant to section 1927 of title XIX of the  
542.3 Social Security Act; and

542.4 ~~(7)~~ (6) medical cannabis as defined in section 152.22, subdivision 6.

542.5 (c) If a single-source drug used by at least two percent of the fee-for-service medical  
542.6 assistance recipients is removed from the formulary due to the failure of the manufacturer  
542.7 to sign a rebate agreement with the Department of Health and Human Services, the  
542.8 commissioner shall notify prescribing practitioners within 30 days of receiving notification  
542.9 from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was  
542.10 not signed.

542.11 Sec. 26. Minnesota Statutes 2018, section 256B.0625, subdivision 13e, is amended to  
542.12 read:

542.13 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall  
542.14 be the lower of the actual acquisition ingredient costs of the drugs or the maximum allowable  
542.15 cost by the commissioner plus the fixed professional dispensing fee; or the usual and  
542.16 customary price charged to the public. The usual and customary price means the lowest  
542.17 price charged by the provider to a patient who pays for the prescription by cash, check, or  
542.18 charge account and includes prices the pharmacy charges to a patient enrolled in a  
542.19 prescription savings club or prescription discount club administered by the pharmacy or  
542.20 pharmacy chain. The amount of payment basis must be reduced to reflect all discount

277.22 Sec. 14. Minnesota Statutes 2018, section 256B.0625, subdivision 13e, is amended to  
277.23 read:

277.24 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall  
277.25 be the lower of the actual acquisition ingredient costs of the drugs or the maximum allowable  
277.26 cost by the commissioner plus the fixed professional dispensing fee; or the usual and  
277.27 customary price charged to the public. The usual and customary price means the lowest  
277.28 price charged by the provider to a patient who pays for the prescription by cash, check, or  
277.29 charge account and includes prices the pharmacy charges to a patient enrolled in a  
277.30 prescription savings club or prescription discount club administered by the pharmacy or  
277.31 pharmacy chain. The amount of payment basis must be reduced to reflect all discount

542.21 amounts applied to the charge by any third-party provider/insurer agreement or contract for  
 542.22 submitted charges to medical assistance programs. The net submitted charge may not be  
 542.23 greater than the patient liability for the service. The ~~pharmacy~~ professional dispensing fee  
 542.24 shall be ~~\$3.65~~ \$10.48 for legend prescription drugs, except that prescriptions filled with  
 542.25 legend drugs meeting the definition of "covered outpatient drugs" according to United States  
 542.26 Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions ~~which~~  
 542.27 that must be compounded by the pharmacist shall be ~~\$8~~ \$10.48 per bag, \$14 per bag for  
 542.28 cancer chemotherapy products, and \$30 per bag for total parenteral nutritional products  
 542.29 dispensed in one liter quantities, or \$44 per bag for total parenteral nutritional products  
 542.30 dispensed in quantities greater than one liter. The professional dispensing fee for  
 542.31 prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient  
 542.32 drugs shall be \$10.48 for dispensed quantities equal to or greater than the number of units  
 542.33 contained in the manufacturer's original package. The professional dispensing fee shall be  
 542.34 prorated based on the percentage of the package dispensed when the pharmacy dispenses  
 543.1 a quantity less than the number of units contained in the manufacturer's original package.  
 543.2 The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition  
 543.3 of covered outpatient drugs shall be \$3.65, except that the fee shall be \$1.31 for  
 543.4 retrospectively billing pharmacies when billing for quantities less than the number of units  
 543.5 contained in the manufacturer's original package. Actual acquisition cost includes quantity  
 543.6 and other special discounts except time and cash discounts. The actual acquisition cost of  
 543.7 a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent  
 543.8 for independently owned pharmacies located in a designated rural area within Minnesota,  
 543.9 and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is  
 543.10 "independently owned" if it is one of four or fewer pharmacies under the same ownership  
 543.11 nationally. A "designated rural area" means an area defined as a small rural area or isolated  
 543.12 rural area according to the four-category classification of the Rural Urban Commuting Area  
 543.13 system developed for the United States Health Resources and Services Administration.  
 543.14 Effective January 1, 2014, the actual acquisition for quantities equal to or greater than the  
 543.15 number of units contained in the manufacturer's original package and shall be prorated based  
 543.16 on the percentage of the package dispensed when the pharmacy dispenses a quantity less  
 543.17 than the number of units contained in the manufacturer's original package. The National  
 543.18 Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost  
 543.19 of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate  
 543.20 the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost  
 543.21 of a drug ~~acquired through~~ for a provider participating in the federal 340B Drug Pricing  
 543.22 Program shall be estimated by the commissioner at wholesale acquisition cost minus ~~40~~  
 543.23 ~~percent~~ either the 340B Drug Pricing Program ceiling price established by the Health  
 543.24 Resources and Services Administration or NADAC, whichever is lower. Wholesale  
 543.25 acquisition cost is defined as the manufacturer's list price for a drug or biological to  
 543.26 wholesalers or direct purchasers in the United States, not including prompt pay or other  
 543.27 discounts, rebates, or reductions in price, for the most recent month for which information  
 543.28 is available, as reported in wholesale price guides or other publications of drug or biological  
 543.29 pricing data. The maximum allowable cost of a multisource drug may be set by the

277.32 amounts applied to the charge by any third-party provider/insurer agreement or contract for  
 277.33 submitted charges to medical assistance programs. The net submitted charge may not be  
 277.34 greater than the patient liability for the service. The ~~pharmacy~~ professional dispensing fee  
 278.1 shall be ~~\$3.65~~ \$10.48 for legend prescription drugs, except that prescriptions filled with  
 278.2 legend drugs meeting the definition of "covered outpatient drugs" according to United States  
 278.3 Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions ~~which~~  
 278.4 that must be compounded by the pharmacist shall be ~~\$8~~ \$10.48 per bag, \$14 per bag for  
 278.5 cancer chemotherapy products, and \$30 per bag for total parenteral nutritional products  
 278.6 dispensed in one liter quantities, or \$44 per bag for total parenteral nutritional products  
 278.7 dispensed in quantities greater than one liter. The professional dispensing fee for  
 278.8 prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient  
 278.9 drugs shall be \$10.48 for dispensed quantities equal to or greater than the number of units  
 278.10 contained in the manufacturer's original package. The professional dispensing fee shall be  
 278.11 prorated based on the percentage of the package dispensed when the pharmacy dispenses  
 278.12 a quantity less than the number of units contained in the manufacturer's original package.  
 278.13 The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition  
 278.14 of covered outpatient drugs shall be \$3.65, except that the fee shall be \$1.31 for  
 278.15 retrospectively billing pharmacies when billing for quantities less than the number of units  
 278.16 contained in the manufacturer's original package. Actual acquisition cost includes quantity  
 278.17 and other special discounts except time and cash discounts. The actual acquisition cost of  
 278.18 a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent  
 278.19 for independently owned pharmacies located in a designated rural area within Minnesota,  
 278.20 and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is  
 278.21 "independently owned" if it is one of four or fewer pharmacies under the same ownership  
 278.22 nationally. A "designated rural area" means an area defined as a small rural area or isolated  
 278.23 rural area according to the four-category classification of the Rural Urban Commuting Area  
 278.24 system developed for the United States Health Resources and Services Administration.  
 278.25 Effective January 1, 2014, the actual acquisition for quantities equal to or greater than the  
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 278.27 on the percentage of the package dispensed when the pharmacy dispenses a quantity less  
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 278.29 Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost  
 278.30 of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate  
 278.31 the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost  
 278.32 of a drug ~~acquired through~~ for a provider participating in the federal 340B Drug Pricing  
 278.33 Program shall be estimated by the commissioner at wholesale acquisition cost minus ~~40~~  
 278.34 ~~percent~~ either the 340B Drug Pricing Program ceiling price established by the Health  
 278.35 Resources and Services Administration or NADAC, whichever is lower. Wholesale  
 278.36 acquisition cost is defined as the manufacturer's list price for a drug or biological to  
 279.1 wholesalers or direct purchasers in the United States, not including prompt pay or other  
 279.2 discounts, rebates, or reductions in price, for the most recent month for which information  
 279.3 is available, as reported in wholesale price guides or other publications of drug or biological  
 279.4 pricing data. The maximum allowable cost of a multisource drug may be set by the

543.30 commissioner and it shall be comparable to, ~~but the actual acquisition cost of the drug~~  
 543.31 ~~product and no higher than, the maximum amount paid by other third-party payors in this~~  
 543.32 ~~state who have maximum allowable cost programs~~ the NADAC of the generic product.  
 543.33 Establishment of the amount of payment for drugs shall not be subject to the requirements  
 543.34 of the Administrative Procedure Act.

543.35 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using  
 543.36 an automated drug distribution system meeting the requirements of section 151.58, or a  
 544.1 packaging system meeting the packaging standards set forth in Minnesota Rules, part  
 544.2 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ  
 544.3 retrospective billing for prescription drugs dispensed to long-term care facility residents. A  
 544.4 retrospectively billing pharmacy must submit a claim only for the quantity of medication  
 544.5 used by the enrolled recipient during the defined billing period. A retrospectively billing  
 544.6 pharmacy must use a billing period not less than one calendar month or 30 days.

544.7 (c) ~~An additional dispensing fee of \$.30 may be added to the dispensing fee paid to~~  
 544.8 ~~pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities~~  
 544.9 ~~when a unit dose blister card system, approved by the department, is used. Under this type~~  
 544.10 ~~of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National~~  
 544.11 ~~Drug Code (NDC) from the drug container used to fill the blister card must be identified~~  
 544.12 ~~on the claim to the department. The unit dose blister card containing the drug must meet~~  
 544.13 ~~the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return~~  
 544.14 ~~of unused drugs to the pharmacy for reuse. A pharmacy provider using packaging that meets~~  
 544.15 the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the  
 544.16 department for the actual acquisition cost of all unused drugs that are eligible for reuse,  
 544.17 unless the pharmacy is using retrospective billing. The commissioner may permit the drug  
 544.18 clozapine to be dispensed in a quantity that is less than a 30-day supply.

544.19 (d) ~~Whenever a maximum allowable cost has been set for~~ If a pharmacy dispenses a  
 544.20 multisource drug, ~~payment shall be the lower of the usual and customary price charged to~~  
 544.21 ~~the public or the ingredient cost shall be the NADAC of the generic product or the maximum~~  
 544.22 allowable cost established by the commissioner unless prior authorization for the brand  
 544.23 name product has been granted according to the criteria established by the Drug Formulary  
 544.24 Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated  
 544.25 "dispense as written" on the prescription in a manner consistent with section 151.21,  
 544.26 subdivision 2.

544.27 (e) The basis for determining the amount of payment for drugs administered in an  
 544.28 outpatient setting shall be the lower of the usual and customary cost submitted by the  
 544.29 provider, 106 percent of the average sales price as determined by the United States  
 544.30 Department of Health and Human Services pursuant to title XVIII, section 1847a of the  
 544.31 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost  
 544.32 set by the commissioner. If average sales price is unavailable, the amount of payment must  
 544.33 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition  
 544.34 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.

279.5 commissioner and it shall be comparable to, ~~but the actual acquisition cost of the drug~~  
 279.6 ~~product and no higher than, the maximum amount paid by other third-party payors in this~~  
 279.7 ~~state who have maximum allowable cost programs~~ the NADAC of the generic product.  
 279.8 Establishment of the amount of payment for drugs shall not be subject to the requirements  
 279.9 of the Administrative Procedure Act.

279.10 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using  
 279.11 an automated drug distribution system meeting the requirements of section 151.58, or a  
 279.12 packaging system meeting the packaging standards set forth in Minnesota Rules, part  
 279.13 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ  
 279.14 retrospective billing for prescription drugs dispensed to long-term care facility residents. A  
 279.15 retrospectively billing pharmacy must submit a claim only for the quantity of medication  
 279.16 used by the enrolled recipient during the defined billing period. A retrospectively billing  
 279.17 pharmacy must use a billing period not less than one calendar month or 30 days.

279.18 (c) ~~An additional dispensing fee of \$.30 may be added to the dispensing fee paid to~~  
 279.19 ~~pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities~~  
 279.20 ~~when a unit dose blister card system, approved by the department, is used. Under this type~~  
 279.21 ~~of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National~~  
 279.22 ~~Drug Code (NDC) from the drug container used to fill the blister card must be identified~~  
 279.23 ~~on the claim to the department. The unit dose blister card containing the drug must meet~~  
 279.24 ~~the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return~~  
 279.25 ~~of unused drugs to the pharmacy for reuse. A pharmacy provider using packaging that meets~~  
 279.26 the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the  
 279.27 department for the actual acquisition cost of all unused drugs that are eligible for reuse,  
 279.28 unless the pharmacy is using retrospective billing. The commissioner may permit the drug  
 279.29 clozapine to be dispensed in a quantity that is less than a 30-day supply.

279.30 (d) ~~Whenever a maximum allowable cost has been set for~~ If a pharmacy dispenses a  
 279.31 multisource drug, ~~payment shall be the lower of the usual and customary price charged to~~  
 279.32 ~~the public or the ingredient cost shall be the NADAC of the generic product or the maximum~~  
 279.33 allowable cost established by the commissioner unless prior authorization for the brand  
 279.34 name product has been granted according to the criteria established by the Drug Formulary  
 279.35 Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated  
 280.1 "dispense as written" on the prescription in a manner consistent with section 151.21,  
 280.2 subdivision 2.

280.3 (e) The basis for determining the amount of payment for drugs administered in an  
 280.4 outpatient setting shall be the lower of the usual and customary cost submitted by the  
 280.5 provider, 106 percent of the average sales price as determined by the United States  
 280.6 Department of Health and Human Services pursuant to title XVIII, section 1847a of the  
 280.7 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost  
 280.8 set by the commissioner. If average sales price is unavailable, the amount of payment must  
 280.9 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition  
 280.10 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.

544.35 ~~Effective January 1, 2014,~~ The commissioner shall discount the payment rate for drugs  
 545.1 obtained through the federal 340B Drug Pricing Program by ~~20~~ 28.6 percent. The payment  
 545.2 for drugs administered in an outpatient setting shall be made to the administering facility  
 545.3 or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an  
 545.4 outpatient setting is not eligible for direct reimbursement.

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

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

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

280.11 ~~Effective January 1, 2014,~~ The commissioner shall discount the payment rate for drugs  
 280.12 obtained through the federal 340B Drug Pricing Program by ~~20~~ 28.6 percent. The payment  
 280.13 for drugs administered in an outpatient setting shall be made to the administering facility  
 280.14 or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an  
 280.15 outpatient setting is not eligible for direct reimbursement.

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

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

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 281.2 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient  
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 281.5 department to dispense outpatient prescription drugs to fee-for-service members must  
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 281.7 section 256B.064 for failure to respond. The commissioner shall require the vendor to  
 281.8 measure a single statewide cost of dispensing for all responding pharmacies to measure the  
 281.9 mean, mean weighted by total prescription volume, mean weighted by medical assistance  
 281.10 prescription volume, median, median weighted by total prescription volume, and median  
 281.11 weighted by total medical assistance prescription volume. The commissioner shall post a  
 281.12 copy of the final cost of dispensing survey report on the department's website. The initial  
 281.13 survey must be completed no later than January 1, 2021, and repeated every three years.  
 281.14 The commissioner shall provide a summary of the results of each cost of dispensing survey  
 281.15 and provide recommendations for any changes to the dispensing fee to the chairs and ranking



546.5 members of the legislative committees with jurisdiction over medical assistance pharmacy  
546.6 reimbursement.

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

546.10 **EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval,  
546.11 whichever is later. Paragraph (i) expires if federal approval is denied. The commissioner  
546.12 of human services shall inform the revisor of statutes when federal approval is obtained or  
546.13 denied.

546.14 Sec. 27. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

546.15 Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and  
546.16 recommend drugs which require prior authorization. The Formulary Committee shall  
546.17 establish general criteria to be used for the prior authorization of brand-name drugs for  
546.18 which generically equivalent drugs are available, but the committee is not required to review  
546.19 each brand-name drug for which a generically equivalent drug is available.

546.20 (b) Prior authorization may be required by the commissioner before certain formulary  
546.21 drugs are eligible for payment. The Formulary Committee may recommend drugs for prior  
546.22 authorization directly to the commissioner. The commissioner may also request that the  
546.23 Formulary Committee review a drug for prior authorization. Before the commissioner may  
546.24 require prior authorization for a drug:

546.25 (1) the commissioner must provide information to the Formulary Committee on the  
546.26 impact that placing the drug on prior authorization may have on the quality of patient care  
546.27 and on program costs, information regarding whether the drug is subject to clinical abuse  
546.28 or misuse, and relevant data from the state Medicaid program if such data is available;

546.29 (2) the Formulary Committee must review the drug, taking into account medical and  
546.30 clinical data and the information provided by the commissioner; and

546.31 (3) the Formulary Committee must hold a public forum and receive public comment for  
546.32 an additional 15 days.

547.1 The commissioner must provide a 15-day notice period before implementing the prior  
547.2 authorization.

547.3 (c) Except as provided in subdivision 13j, prior authorization shall not be required or  
547.4 utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness  
547.5 if:

547.6 (1) there is no generically equivalent drug available; and

547.7 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

547.8 (3) the drug is part of the recipient's current course of treatment.

281.16 members of the legislative committees with jurisdiction over medical assistance pharmacy  
281.17 reimbursement.

281.18 **EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval,  
281.19 whichever is later. The commissioner of human services shall inform the revisor of statutes  
281.20 when federal approval is obtained or denied.

281.21 Sec. 15. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

281.22 Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and  
281.23 recommend drugs which require prior authorization. The Formulary Committee shall  
281.24 establish general criteria to be used for the prior authorization of brand-name drugs for  
281.25 which generically equivalent drugs are available, but the committee is not required to review  
281.26 each brand-name drug for which a generically equivalent drug is available.

281.27 (b) Prior authorization may be required by the commissioner before certain formulary  
281.28 drugs are eligible for payment. The Formulary Committee may recommend drugs for prior  
281.29 authorization directly to the commissioner. The commissioner may also request that the  
281.30 Formulary Committee review a drug for prior authorization. Before the commissioner may  
281.31 require prior authorization for a drug:

281.32 (1) the commissioner must provide information to the Formulary Committee on the  
281.33 impact that placing the drug on prior authorization may have on the quality of patient care  
282.1 and on program costs, information regarding whether the drug is subject to clinical abuse  
282.2 or misuse, and relevant data from the state Medicaid program if such data is available;

282.3 (2) the Formulary Committee must review the drug, taking into account medical and  
282.4 clinical data and the information provided by the commissioner; and

282.5 (3) the Formulary Committee must hold a public forum and receive public comment for  
282.6 an additional 15 days.

282.7 The commissioner must provide a 15-day notice period before implementing the prior  
282.8 authorization.

282.9 (c) Except as provided in subdivision 13j, prior authorization shall not be required or  
282.10 utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness  
282.11 if:

282.12 (1) there is no generically equivalent drug available; and

282.13 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

282.14 (3) the drug is part of the recipient's current course of treatment.

547.9 This paragraph applies to any multistate preferred drug list or supplemental drug rebate  
 547.10 program established or administered by the commissioner. Prior authorization shall  
 547.11 automatically be granted for 60 days for brand name drugs prescribed for treatment of mental  
 547.12 illness within 60 days of when a generically equivalent drug becomes available, provided  
 547.13 that the brand name drug was part of the recipient's course of treatment at the time the  
 547.14 generically equivalent drug became available.

547.15 ~~(d) Prior authorization shall not be required or utilized for any antihemophilic factor~~  
 547.16 ~~drug prescribed for the treatment of hemophilia and blood disorders where there is no~~  
 547.17 ~~generically equivalent drug available if the prior authorization is used in conjunction with~~  
 547.18 ~~any supplemental drug rebate program or multistate preferred drug list established or~~  
 547.19 ~~administered by the commissioner.~~

547.20 ~~(e)~~ (d) The commissioner may require prior authorization for brand name drugs whenever  
 547.21 a generically equivalent product is available, even if the prescriber specifically indicates  
 547.22 "dispense as written-brand necessary" on the prescription as required by section 151.21,  
 547.23 subdivision 2.

547.24 ~~(f)~~ (e) Notwithstanding this subdivision, the commissioner may automatically require  
 547.25 prior authorization, for a period not to exceed 180 days, for any drug that is approved by  
 547.26 the United States Food and Drug Administration on or after July 1, 2005. The 180-day  
 547.27 period begins no later than the first day that a drug is available for shipment to pharmacies  
 547.28 within the state. The Formulary Committee shall recommend to the commissioner general  
 547.29 criteria to be used for the prior authorization of the drugs, but the committee is not required  
 547.30 to review each individual drug. In order to continue prior authorizations for a drug after the  
 547.31 180-day period has expired, the commissioner must follow the provisions of this subdivision.

547.32 (f) Prior authorization under this subdivision shall comply with section 62Q.184.

548.1 **EFFECTIVE DATE.** This section is effective the day following final enactment, except  
 548.2 that paragraph (f) is effective July 1, 2019.

548.3 Sec. 28. Minnesota Statutes 2018, section 256B.0625, subdivision 17, is amended to read:

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

548.8 (b) Medical assistance covers medical transportation costs incurred solely for obtaining  
 548.9 emergency medical care or transportation costs incurred by eligible persons in obtaining  
 548.10 emergency or nonemergency medical care when paid directly to an ambulance company,  
 548.11 nonemergency medical transportation company, or other recognized providers of  
 548.12 transportation services. Medical transportation must be provided by:

282.15 This paragraph applies to any multistate preferred drug list or supplemental drug rebate  
 282.16 program established or administered by the commissioner. Prior authorization shall  
 282.17 automatically be granted for 60 days for brand name drugs prescribed for treatment of mental  
 282.18 illness within 60 days of when a generically equivalent drug becomes available, provided  
 282.19 that the brand name drug was part of the recipient's course of treatment at the time the  
 282.20 generically equivalent drug became available.

282.21 ~~(d) Prior authorization shall not be required or utilized for any antihemophilic factor~~  
 282.22 ~~drug prescribed for the treatment of hemophilia and blood disorders where there is no~~  
 282.23 ~~generically equivalent drug available if the prior authorization is used in conjunction with~~  
 282.24 ~~any supplemental drug rebate program or multistate preferred drug list established or~~  
 282.25 ~~administered by the commissioner.~~

282.26 ~~(e)~~ (d) The commissioner may require prior authorization for brand name drugs whenever  
 282.27 a generically equivalent product is available, even if the prescriber specifically indicates  
 282.28 "dispense as written-brand necessary" on the prescription as required by section 151.21,  
 282.29 subdivision 2.

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 282.31 prior authorization, for a period not to exceed 180 days, for any drug that is approved by  
 282.32 the United States Food and Drug Administration on or after July 1, 2005. The 180-day  
 283.1 period begins no later than the first day that a drug is available for shipment to pharmacies  
 283.2 within the state. The Formulary Committee shall recommend to the commissioner general  
 283.3 criteria to be used for the prior authorization of the drugs, but the committee is not required  
 283.4 to review each individual drug. In order to continue prior authorizations for a drug after the  
 283.5 180-day period has expired, the commissioner must follow the provisions of this subdivision.

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

## ARTICLE 1:

26.24 Sec. 27. Minnesota Statutes 2018, section 256B.0625, subdivision 17, is amended to read:

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

26.29 (b) Medical assistance covers medical transportation costs incurred solely for obtaining  
 26.30 emergency medical care or transportation costs incurred by eligible persons in obtaining  
 26.31 emergency or nonemergency medical care when paid directly to an ambulance company,  
 27.1 nonemergency medical transportation company, or other recognized providers of  
 27.2 transportation services. Medical transportation must be provided by:

548.13 (1) nonemergency medical transportation providers who meet the requirements of this  
548.14 subdivision;

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

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

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

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

548.19 (c) Medical assistance covers nonemergency medical transportation provided by  
548.20 nonemergency medical transportation providers enrolled in the Minnesota health care  
548.21 programs. All nonemergency medical transportation providers must comply with the  
548.22 operating standards for special transportation service as defined in sections 174.29 to 174.30  
548.23 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota Department of  
548.24 Transportation all drivers must be individually enrolled with the commissioner and reported  
548.25 on the claim as the individual who provided the service. All nonemergency medical  
548.26 transportation providers shall bill for nonemergency medical transportation services in  
548.27 accordance with Minnesota health care programs criteria. Publicly operated transit systems,  
548.28 volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this  
548.29 paragraph.

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

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

549.1 (2) the provider has initiated background studies on the individuals specified in section  
549.2 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

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

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

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

27.3 (1) nonemergency medical transportation providers who meet the requirements of this  
27.4 subdivision;

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

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

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

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

27.9 (c) Medical assistance covers nonemergency medical transportation provided by  
27.10 nonemergency medical transportation providers enrolled in the Minnesota health care  
27.11 programs. All nonemergency medical transportation providers must comply with the  
27.12 operating standards for special transportation service as defined in sections 174.29 to 174.30  
27.13 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota Department of  
27.14 Transportation. All drivers providing nonemergency medical transportation must be  
27.15 individually enrolled with the commissioner if the driver is a subcontractor for or employed  
27.16 by a provider that both has a base of operation located within a metropolitan county listed  
27.17 in section 473.121, subdivision 4, and is listed in paragraph (b), clause (1) or (3). All  
27.18 nonemergency medical transportation providers shall bill for nonemergency medical  
27.19 transportation services in accordance with Minnesota health care programs criteria. Publicly  
27.20 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the  
27.21 requirements outlined in this paragraph.

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

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

27.25 (2) the provider has initiated background studies on the individuals specified in section  
27.26 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

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

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

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

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

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

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

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

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

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

550.13 (i) The covered modes of transportation are:

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

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

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

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

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

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

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

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

29.6 (i) The covered modes of transportation are:

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

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

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

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

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

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

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

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

551.9 (k) The commissioner shall:

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

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

551.13 (3) investigate all complaints and appeals.

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

551.18 (m) Payments for nonemergency medical transportation must be paid based on the client's  
 551.19 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The  
 551.20 medical assistance reimbursement rates for nonemergency medical transportation services  
 551.21 that are payable by or on behalf of the commissioner for nonemergency medical  
 551.22 transportation services are:

551.23 (1) \$0.22 per mile for client reimbursement;

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

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

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

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

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

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

29.33 (k) The commissioner shall:

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

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

30.4 (3) investigate all complaints and appeals.

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

30.9 (m) Payments for nonemergency medical transportation must be paid based on the client's  
 30.10 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The  
 30.11 medical assistance reimbursement rates for nonemergency medical transportation services  
 30.12 that are payable by or on behalf of the commissioner for nonemergency medical  
 30.13 transportation services are:

30.14 (1) \$0.22 per mile for client reimbursement;

551.24 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer  
551.25 transport;

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

551.29 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

551.30 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

551.31 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

552.1 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for  
552.2 an additional attendant if deemed medically necessary.

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

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

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

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

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

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

552.20 **EFFECTIVE DATE.** This section is effective July 1, 2019.

552.21 Sec. 29. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision  
552.22 to read:

552.23 Subd. 17d. **Transportation services oversight.** The commissioner shall contract with  
552.24 a vendor or dedicate staff to oversee providers of nonemergency medical transportation

30.15 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer  
30.16 transport;

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

30.20 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

30.21 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

30.22 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

30.23 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for  
30.24 an additional attendant if deemed medically necessary.

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

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

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

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

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

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

31.12 **EFFECTIVE DATE.** This section is effective January 1, 2020.

#### ARTICLE 1:

31.13 Sec. 28. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision  
31.14 to read:

31.15 Subd. 17d. **Transportation services oversight.** The commissioner shall contract with  
31.16 a vendor or dedicate staff for oversight of providers of nonemergency medical transportation

552.25 services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules,  
552.26 parts 9505.2160 to 9505.2245.

552.27 **EFFECTIVE DATE.** This section is effective July 1, 2019.

552.28 Sec. 30. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision  
552.29 to read:

552.30 Subd. 17e. **Transportation provider termination.** (a) A terminated nonemergency  
552.31 medical transportation provider, including all named individuals on the current enrollment  
553.1 disclosure form and known or discovered affiliates of the nonemergency medical  
553.2 transportation provider, is not eligible to enroll as a nonemergency medical transportation  
553.3 provider for five years following the termination.

553.4 (b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a  
553.5 nonemergency medical transportation provider, the provider must be placed on a one-year  
553.6 probation period. During a provider's probation period the commissioner shall complete  
553.7 unannounced site visits and request documentation to review compliance with program  
553.8 requirements.

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

31.17 services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules,  
31.18 parts 9505.2160 to 9505.2245.

31.19 **EFFECTIVE DATE.** This section is effective January 1, 2020.

#### ARTICLE 1:

31.20 Sec. 29. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision  
31.21 to read:

31.22 Subd. 17e. **Transportation provider termination.** (a) A terminated nonemergency  
31.23 medical transportation provider, including all named individuals on the current enrollment  
31.24 disclosure form and known or discovered affiliates of the nonemergency medical  
31.25 transportation provider, is not eligible to enroll as a nonemergency medical transportation  
31.26 provider for five years following the termination.

31.27 (b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a  
31.28 nonemergency medical transportation provider, the nonemergency medical transportation  
31.29 provider must be placed on a one-year probation period. During a provider's probation  
31.30 period, the commissioner shall complete unannounced site visits and request documentation  
31.31 to review compliance with program requirements.

#### ARTICLE 1:

32.1 Sec. 30. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision  
32.2 to read:

32.3 Subd. 17f. **Transportation provider training.** The commissioner shall make available  
32.4 to providers of nonemergency medical transportation and all drivers training materials and  
32.5 online training opportunities regarding documentation requirements, documentation  
32.6 procedures, and penalties for failing to meet documentation requirements.

#### ARTICLE 8:

283.7 Sec. 16. Minnesota Statutes 2018, section 256B.0625, subdivision 18d, is amended to  
283.8 read:

283.9 Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical  
283.10 Transportation Advisory Committee consists of:

283.11 (1) four voting members who represent counties, utilizing the rural urban commuting  
283.12 area classification system. As defined in subdivision 17, these members shall be designated  
283.13 as follows:

283.14 (i) two counties within the 11-county metropolitan area;

- 283.15 (ii) one county representing the rural area of the state; and
- 283.16 (iii) one county representing the super rural area of the state.
- 283.17 The Association of Minnesota Counties shall appoint one county within the 11-county  
283.18 metropolitan area and one county representing the super rural area of the state. The Minnesota  
283.19 Inter-County Association shall appoint one county within the 11-county metropolitan area  
283.20 and one county representing the rural area of the state;
- 283.21 (2) three voting members who represent medical assistance recipients, including persons  
283.22 with physical and developmental disabilities, persons with mental illness, seniors, children,  
283.23 and low-income individuals;
- 283.24 (3) ~~four~~ five voting members who represent providers that deliver nonemergency medical  
283.25 transportation services to medical assistance enrollees, one of whom is a taxicab owner or  
283.26 operator;
- 283.27 (4) two voting members of the house of representatives, one from the majority party and  
283.28 one from the minority party, appointed by the speaker of the house, and two voting members  
283.29 from the senate, one from the majority party and one from the minority party, appointed by  
283.30 the Subcommittee on Committees of the Committee on Rules and Administration;
- 283.31 (5) one voting member who represents demonstration providers as defined in section  
283.32 256B.69, subdivision 2;
- 284.1 (6) one voting member who represents an organization that contracts with state or local  
284.2 governments to coordinate transportation services for medical assistance enrollees;
- 284.3 (7) one voting member who represents the Minnesota State Council on Disability;
- 284.4 (8) the commissioner of transportation or the commissioner's designee, who shall serve  
284.5 as a voting member;
- 284.6 (9) one voting member appointed by the Minnesota Ambulance Association; and
- 284.7 (10) one voting member appointed by the Minnesota Hospital Association.
- 284.8 (b) Members of the advisory committee shall not be employed by the Department of  
284.9 Human Services. Members of the advisory committee shall receive no compensation.

## ARTICLE 1:

- 32.7 Sec. 31. Minnesota Statutes 2018, section 256B.0625, subdivision 18h, is amended to  
32.8 read:
- 32.9 Subd. 18h. **Managed care.** ~~(a)~~ The following subdivisions apply to managed care plans  
32.10 and county-based purchasing plans:
- 32.11 (1) subdivision 17, paragraphs (a), (b), (c), (i), and (n);
- 32.12 (2) subdivision 18; and



553.10 Sec. 31. Minnesota Statutes 2018, section 256B.0625, subdivision 30, is amended to read:

553.11 Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services,  
553.12 federally qualified health center services, nonprofit community health clinic services, and  
553.13 public health clinic services. Rural health clinic services and federally qualified health center  
553.14 services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and  
553.15 (C). Payment for rural health clinic and federally qualified health center services shall be  
553.16 made according to applicable federal law and regulation.

553.17 (b) A federally qualified health center (FQHC) that is beginning initial operation shall  
553.18 submit an estimate of budgeted costs and visits for the initial reporting period in the form  
553.19 and detail required by the commissioner. ~~A federally qualified health center~~ An FQHC that  
553.20 is already in operation shall submit an initial report using actual costs and visits for the  
553.21 initial reporting period. Within 90 days of the end of its reporting period, ~~a federally qualified~~  
553.22 ~~health center~~ an FQHC shall submit, in the form and detail required by the commissioner,  
553.23 a report of its operations, including allowable costs actually incurred for the period and the  
553.24 actual number of visits for services furnished during the period, and other information  
553.25 required by the commissioner. ~~Federally qualified health centers~~ FQHCs that file Medicare  
553.26 cost reports shall provide the commissioner with a copy of the most recent Medicare cost  
553.27 report filed with the Medicare program intermediary for the reporting year which support  
553.28 the costs claimed on their cost report to the state.

553.29 (c) In order to continue cost-based payment under the medical assistance program  
553.30 according to paragraphs (a) and (b), ~~a federally qualified health center~~ an FQHC or rural  
553.31 health clinic must apply for designation as an essential community provider within six  
553.32 months of final adoption of rules by the Department of Health according to section 62Q.19,  
553.33 subdivision 7. For those ~~federally qualified health centers~~ FQHCs and rural health clinics  
553.34 that have applied for essential community provider status within the six-month time  
554.1 prescribed, medical assistance payments will continue to be made according to paragraphs  
554.2 (a) and (b) for the first three years after application. For ~~federally qualified health centers~~  
554.3 FQHCs and rural health clinics that either do not apply within the time specified above or  
554.4 who have had essential community provider status for three years, medical assistance  
554.5 payments for health services provided by these entities shall be according to the same rates  
554.6 and conditions applicable to the same service provided by health care providers that are not  
554.7 ~~federally qualified health centers~~ FQHCs or rural health clinics.

554.8 (d) Effective July 1, 1999, the provisions of paragraph (c) requiring ~~a federally qualified~~  
554.9 ~~health center~~ an FQHC or a rural health clinic to make application for an essential community

32.13 (3) subdivision 18a.

32.14 (b) A nonemergency medical transportation provider must comply with the operating  
32.15 standards for special transportation service specified in sections 174.29 to 174.30 and  
32.16 Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire  
32.17 vehicles are exempt from the requirements in this paragraph.

554.10 provider designation in order to have cost-based payments made according to paragraphs  
 554.11 (a) and (b) no longer apply.

554.12 (e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall  
 554.13 be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

554.14 (f) Effective January 1, 2001, through December 31, 2020, each ~~federally qualified~~  
 554.15 ~~health center~~ FQHC and rural health clinic may elect to be paid either under the prospective  
 554.16 payment system established in United States Code, title 42, section 1396a(aa), or under an  
 554.17 alternative payment methodology consistent with the requirements of United States Code,  
 554.18 title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services.  
 554.19 The alternative payment methodology shall be 100 percent of cost as determined according  
 554.20 to Medicare cost principles.

554.21 (g) Effective for services provided on or after January 1, 2021, all claims for payment  
 554.22 of clinic services provided by FQHCs and rural health clinics shall be paid by the  
 554.23 commissioner, according to an annual election by the FQHC or rural health clinic, under  
 554.24 the current prospective payment system described in paragraph (f) or the alternative payment  
 554.25 methodology described in paragraph (l).

554.26 (h) For purposes of this section, "nonprofit community clinic" is a clinic that:

554.27 (1) has nonprofit status as specified in chapter 317A;

554.28 (2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

554.29 (3) is established to provide health services to low-income population groups, uninsured,  
 554.30 high-risk and special needs populations, underserved and other special needs populations;

554.31 (4) employs professional staff at least one-half of which are familiar with the cultural  
 554.32 background of their clients;

555.1 (5) charges for services on a sliding fee scale designed to provide assistance to  
 555.2 low-income clients based on current poverty income guidelines and family size; and

555.3 (6) does not restrict access or services because of a client's financial limitations or public  
 555.4 assistance status and provides no-cost care as needed.

555.5 ~~(h)~~ (i) Effective for services provided on or after January 1, 2015, all claims for payment  
 555.6 of clinic services provided by ~~federally qualified health centers~~ FQHCs and rural health  
 555.7 clinics shall be paid by the commissioner. the commissioner shall determine the most feasible  
 555.8 method for paying claims from the following options:

555.9 (1) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims  
 555.10 directly to the commissioner for payment, and the commissioner provides claims information  
 555.11 for recipients enrolled in a managed care or county-based purchasing plan to the plan, on  
 555.12 a regular basis; or

555.13 ~~(2) federally qualified health centers~~ FQHCs and rural health clinics submit claims for  
555.14 recipients enrolled in a managed care or county-based purchasing plan to the plan, and those  
555.15 claims are submitted by the plan to the commissioner for payment to the clinic.

555.16 ~~(j)~~ (j) For clinic services provided prior to January 1, 2015, the commissioner shall  
555.17 calculate and pay monthly the proposed managed care supplemental payments to clinics,  
555.18 and clinics shall conduct a timely review of the payment calculation data in order to finalize  
555.19 all supplemental payments in accordance with federal law. Any issues arising from a clinic's  
555.20 review must be reported to the commissioner by January 1, 2017. Upon final agreement  
555.21 between the commissioner and a clinic on issues identified under this subdivision, and in  
555.22 accordance with United States Code, title 42, section 1396a(bb), no supplemental payments  
555.23 for managed care plan or county-based purchasing plan claims for services provided prior  
555.24 to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are  
555.25 unable to resolve issues under this subdivision, the parties shall submit the dispute to the  
555.26 arbitration process under section 14.57.

555.27 ~~(k)~~ (k) The commissioner shall seek a federal waiver, authorized under section 1115 of  
555.28 the Social Security Act, to obtain federal financial participation at the 100 percent federal  
555.29 matching percentage available to facilities of the Indian Health Service or tribal organization  
555.30 in accordance with section 1905(b) of the Social Security Act for expenditures made to  
555.31 organizations dually certified under Title V of the Indian Health Care Improvement Act,  
555.32 Public Law 94-437, and as a federally qualified health center under paragraph (a) that  
555.33 provides services to American Indian and Alaskan Native individuals eligible for services  
555.34 under this subdivision.

556.1 (l) All claims for payment of clinic services provided by FQHCs and rural health clinics,  
556.2 that have elected to be paid under this paragraph, shall be paid by the commissioner according  
556.3 to the following requirements:

556.4 (1) the commissioner shall establish a single medical and single dental organization rate  
556.5 for each FQHC and rural health clinic when applicable;

556.6 (2) each FQHC and rural health clinic is eligible for same day reimbursement of one  
556.7 medical and one dental organization rate if eligible medical and dental visits are provided  
556.8 on the same day;

556.9 (3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance  
556.10 with current applicable Medicare cost principles, their allowable costs, including direct  
556.11 patient care costs and patient-related support services. Nonallowable costs include, but are  
556.12 not limited to:

556.13 (i) general social service and administrative costs;

556.14 (ii) retail pharmacy;

556.15 (iii) patient incentives, food, housing assistance, and utility assistance;

- 556.16 (iv) external lab and x-ray;
- 556.17 (v) navigation services;
- 556.18 (vi) health care taxes;
- 556.19 (vii) advertising, public relations, and marketing;
- 556.20 (viii) office entertainment costs, food, alcohol, and gifts;
- 556.21 (ix) contributions and donations;
- 556.22 (x) bad debts or losses on awards or contracts;
- 556.23 (xi) fines, penalties, damages, or other settlements;
- 556.24 (xii) fund-raising, investment management, and associated administrative costs;
- 556.25 (xiii) research and associated administrative costs;
- 556.26 (xiv) nonpaid workers;
- 556.27 (xv) lobbying;
- 556.28 (xvi) scholarships and student aid; and
- 556.29 (xvii) nonmedical assistance covered services;
- 557.1 (4) the commissioner shall review the list of nonallowable costs in the years between
- 557.2 the rebasing process established in clause (5), in consultation with the Minnesota Association
- 557.3 of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall
- 557.4 publish the list and any updates in the Minnesota health care programs provider manual;
- 557.5 (5) the initial applicable base year organization rates for FQHCs and rural health clinics
- 557.6 shall be computed for services delivered on or after January 1, 2021, and:
- 557.7 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports
- 557.8 from both 2017 and 2018;
- 557.9 (ii) must be according to current applicable Medicare cost principles as applicable to
- 557.10 FQHCs and rural health clinics without the application of productivity screens and upper
- 557.11 payment limits or the Medicare prospective payment system FQHC aggregate mean upper
- 557.12 payment limit;
- 557.13 (iii) must be subsequently rebased every two years thereafter using the Medicare cost
- 557.14 reports that are three and four years prior to the rebasing year;
- 557.15 (iv) must be inflated to the base year using the inflation factor described in clause (6);
- 557.16 and
- 557.17 (v) the commissioner must provide for a 60-day appeals process under section 14.57;

557.18 (6) the commissioner shall annually inflate the applicable organization rates for FQHCs  
557.19 and rural health clinics from the base year payment rate to the effective date by using the  
557.20 CMS FQHC Market Basket inflator established under United States Code, title 42, section  
557.21 1395m(o), less productivity;

557.22 (7) FQHCs and rural health clinics that have elected the alternative payment methodology  
557.23 under this paragraph shall submit all necessary documentation required by the commissioner  
557.24 to compute the rebased organization rates no later than six months following the date the  
557.25 applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

557.26 (8) the commissioner shall reimburse FQHCs and rural health clinics an additional  
557.27 amount relative to their medical and dental organization rates that is attributable to the tax  
557.28 required to be paid according to section 295.52, if applicable;

557.29 (9) FQHCs and rural health clinics may submit change of scope requests to the  
557.30 commissioner if the change of scope would result in an increase or decrease of 2.5 percent  
557.31 or higher in the medical or dental organization rate currently received by the FQHC or rural  
557.32 health clinic;

558.1 (10) For FQHCs and rural health clinics seeking a change in scope with the commissioner  
558.2 under clause (9) that requires the approval of the scope change by the federal Health  
558.3 Resources Services Administration;

558.4 (i) FQHCs and rural health clinics shall submit the change of scope request, including  
558.5 the start date of services, to the commissioner within seven business days of submission of  
558.6 the scope change to the federal Health Resources Services Administration;

558.7 (ii) the commissioner shall establish the effective date of the payment change as the  
558.8 federal Health Resources Services Administration date of approval of the FQHC's or rural  
558.9 health clinic's scope change request, or the effective start date of services, whichever is  
558.10 later; and

558.11 (iii) within 45 days of one year after the effective date established in item (ii), the  
558.12 commissioner shall conduct a retroactive review to determine if the actual costs established  
558.13 under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in  
558.14 the medical or dental organization rate, and if this is the case, the commissioner shall revise  
558.15 the rate accordingly and shall adjust payments retrospectively to the effective date established  
558.16 in item (ii);

558.17 (11) for change of scope requests that do not require federal Health Resources Services  
558.18 Administration approval, the FQHC and rural health clinic shall submit the request to the  
558.19 commissioner before implementing the change, and the effective date of the change is the  
558.20 date the commissioner received the FQHC's or rural health clinic's request, or the effective  
558.21 start date of the service, whichever is later. The commissioner shall provide a response to  
558.22 the FQHC's or rural health clinic's request within 45 days of submission and provide a final  
558.23 approval within 120 days of submission. This timeline may be waived at the mutual

558.24 agreement of the commissioner and the FQHC or rural health clinic if more information is  
558.25 needed to evaluate the request;

558.26 (12) the commissioner, when establishing organization rates for new FQHCs and rural  
558.27 health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics  
558.28 in a 60-mile radius for organizations established outside of the seven-county metropolitan  
558.29 area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this  
558.30 information is not available, the commissioner may use Medicare cost reports or audited  
558.31 financial statements to establish base rate;

558.32 (13) the commissioner shall establish a quality measures workgroup that includes  
558.33 representatives from the Minnesota Association of Community Health Centers, FQHCs,  
558.34 and rural health clinics, to evaluate clinical and nonclinical measures; and

559.1 (14) the commissioner shall not disallow or reduce costs that are related to an FQHC's  
559.2 or rural health clinic's participation in health care educational programs to the extent that  
559.3 the costs are not accounted for in the alternative payment methodology encounter rate  
559.4 established in this paragraph.

559.5 Sec. 32. Minnesota Statutes 2018, section 256B.0625, subdivision 31, is amended to read:

559.6 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical  
559.7 supplies and equipment. Separate payment outside of the facility's payment rate shall be  
559.8 made for wheelchairs and wheelchair accessories for recipients who are residents of  
559.9 intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs  
559.10 and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions  
559.11 and limitations as coverage for recipients who do not reside in institutions. A wheelchair  
559.12 purchased outside of the facility's payment rate is the property of the recipient.

559.13 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies  
559.14 must enroll as a Medicare provider.

559.15 (c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics,  
559.16 or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment  
559.17 requirement if:

559.18 (1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic,  
559.19 or medical supply;

559.20 (2) the vendor serves ten or fewer medical assistance recipients per year;

559.21 (3) the commissioner finds that other vendors are not available to provide same or similar  
559.22 durable medical equipment, prosthetics, orthotics, or medical supplies; and

559.23 (4) the vendor complies with all screening requirements in this chapter and Code of  
559.24 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from  
559.25 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare  
559.26 and Medicaid Services approved national accreditation organization as complying with the

559.27 Medicare program's supplier and quality standards and the vendor serves primarily pediatric  
559.28 patients.

559.29 (d) Durable medical equipment means a device or equipment that:

559.30 (1) can withstand repeated use;

559.31 (2) is generally not useful in the absence of an illness, injury, or disability; and

560.1 (3) is provided to correct or accommodate a physiological disorder or physical condition  
560.2 or is generally used primarily for a medical purpose.

560.3 (e) Electronic tablets may be considered durable medical equipment if the electronic  
560.4 tablet will be used as an augmentative and alternative communication system as defined  
560.5 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must  
560.6 be locked in order to prevent use not related to communication.

560.7 (f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be  
560.8 locked to prevent use not as an augmentative communication device, a recipient of waiver  
560.9 services may use an electronic tablet for a use not related to communication when the  
560.10 recipient has been authorized under the waiver to receive one or more additional applications  
560.11 that can be loaded onto the electronic tablet, such that allowing the additional use prevents  
560.12 the purchase of a separate electronic tablet with waiver funds.

560.13 (g) An order or prescription for medical supplies, equipment, or appliances must meet  
560.14 the requirements in Code of Federal Regulations, title 42, part 440.70.

560.15 (h) Allergen-reducing products provided according to subdivision 66, paragraph (c),  
560.16 shall be considered durable medical equipment.

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

560.20 Sec. 33. Minnesota Statutes 2018, section 256B.0625, subdivision 57, is amended to read:

560.21 Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services  
560.22 provided on or after January 1, 2012, medical assistance payment for an enrollee's  
560.23 cost-sharing associated with Medicare Part B is limited to an amount up to the medical  
560.24 assistance total allowed, when the medical assistance rate exceeds the amount paid by  
560.25 Medicare.

560.26 (b) Excluded from this limitation are payments for mental health services and payments  
560.27 for dialysis services provided to end-stage renal disease patients. The exclusion for mental  
560.28 health services does not apply to payments for physician services provided by psychiatrists  
560.29 and advanced practice nurses with a specialty in mental health.

560.30 (c) Excluded from this limitation are payments to federally qualified health centers,  
560.31 Indian Health Services, and rural health clinics.



- 560.32 **EFFECTIVE DATE.** This section is effective the day following final enactment.
- 561.1 Sec. 34. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
- 561.2 to read:
- 561.3 Subd. 66. **Enhanced asthma care services.** (a) Medical assistance covers enhanced
- 561.4 asthma care services and related products to be provided in the children's homes for children
- 561.5 with poorly controlled asthma. To be eligible for services and products under this subdivision,
- 561.6 a child must:
- 561.7 (1) be under the age of 21;
- 561.8 (2) have poorly controlled asthma defined by having received health care for the child's
- 561.9 asthma from a hospital emergency department at least one time in the past year or have
- 561.10 been hospitalized for the treatment of asthma at least one time in the past year; and
- 561.11 (3) receive a referral for services and products under this subdivision from a treating
- 561.12 health care provider.
- 561.13 (b) Covered services include home visits provided by a registered environmental health
- 561.14 specialist or lead risk assessor currently credentialed by the Department of Health or a
- 561.15 healthy homes specialist credentialed by the Building Performance Institute.
- 561.16 (c) Covered products include the following allergen-reducing products that are identified
- 561.17 as needed, and recommended for the child, by a registered environmental health specialist,
- 561.18 healthy homes specialist, lead risk assessor, certified asthma educator, public health nurse,
- 561.19 or other health care professional providing asthma care for the child, and proven to reduce
- 561.20 asthma triggers:
- 561.21 (1) allergen encasements for mattresses, box springs, and pillows;
- 561.22 (2) an allergen-rated vacuum cleaner, filters, and bags;
- 561.23 (3) a dehumidifier and filters;
- 561.24 (4) HEPA single-room air cleaners and filters;
- 561.25 (5) integrated pest management, including traps and starter packages of food storage
- 561.26 containers;
- 561.27 (6) a damp mopping system;
- 561.28 (7) if the child does not have access to a bed, a waterproof hospital-grade mattress; and
- 561.29 (8) for homeowners only, furnace filters.
- 561.30 The commissioner shall determine additional products that may be covered as new best
- 561.31 practices for asthma care are identified.
- 562.1 (d) A home assessment is a home visit to identify asthma triggers in the home and to
- 562.2 provide education on trigger-reducing products. A child is limited to two home assessments



562.3 except that a child may receive an additional home assessment if the child moves to a new  
562.4 home; if a new asthma trigger, including tobacco smoke, enters the home; or if the child's  
562.5 health care provider identifies a new allergy for the child, including an allergy to mold,  
562.6 pests, pets, or dust mites. The commissioner shall determine the frequency with which a  
562.7 child may receive a product listed in paragraph (c), based on the reasonable expected lifetime  
562.8 of the product.

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

562.12 Sec. 35. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision  
562.13 to read:

562.14 Subd. 67. **Provider tax rate increase.** (a) The commissioner shall increase the total  
562.15 payments to managed care plans under section 256B.69 by an amount equal to the cost  
562.16 increases to the managed care plans from the elimination of:

562.17 (1) the exemption from the taxes imposed under section 297I.05, subdivision 5, for  
562.18 premiums paid by the state for medical assistance and the MinnesotaCare program; and

562.19 (2) the exemption of gross revenues subject to the taxes imposed under sections 295.50  
562.20 to 295.57, for payments paid by the state for services provided under medical assistance  
562.21 and the MinnesotaCare program. Any increase based on this clause must be reflected in  
562.22 provider rates paid by the managed care plan unless the managed care plan is a staff model  
562.23 health plan company.

562.24 (b) The commissioner shall increase by two percent the fee-for-service payments under  
562.25 medical assistance and the MinnesotaCare program for services subject to the hospital,  
562.26 surgical center, or health care provider taxes under sections 295.50 to 295.57.

#### ARTICLE 8:

284.10 Sec. 17. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision  
284.11 to read:

284.12 Subd. 66. **Prescribed pediatric extended care (PPEC) center basic services.** Medical  
284.13 assistance covers PPEC center basic services as defined under section 144H.01, subdivision  
284.14 2. PPEC basic services shall be reimbursed according to section 256B.86.

284.15 **EFFECTIVE DATE.** This section is effective July 1, 2020, or upon federal approval,  
284.16 whichever occurs later. The commissioner of human services shall notify the commissioner  
284.17 of health and the revisor of statutes when federal approval is obtained.

562.27 Sec. 36. Minnesota Statutes 2018, section 256B.064, subdivision 1a, is amended to read:

562.28 Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose  
562.29 sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse  
562.30 in connection with the provision of medical care to recipients of public assistance; (2) a  
562.31 pattern of presentment of false or duplicate claims or claims for services not medically  
562.32 necessary; (3) a pattern of making false statements of material facts for the purpose of  
563.1 obtaining greater compensation than that to which the vendor is legally entitled; (4)  
563.2 suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access  
563.3 during regular business hours to examine all records necessary to disclose the extent of  
563.4 services provided to program recipients and appropriateness of claims for payment; (6)  
563.5 failure to repay an overpayment or a fine finally established under this section; (7) failure  
563.6 to correct errors in the maintenance of health service or financial records for which a fine  
563.7 was imposed or after issuance of a warning by the commissioner; and (8) any reason for  
563.8 which a vendor could be excluded from participation in the Medicare program under section  
563.9 1128, 1128A, or 1866(b)(2) of the Social Security Act.

563.10 (b) The commissioner may impose sanctions against a pharmacy provider for failure to  
563.11 respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph  
563.12 (h).

563.13 **EFFECTIVE DATE.** This section is effective April 1, 2019.

563.14 Sec. 37. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

563.15 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**  
563.16 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of  
563.17 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in  
563.18 a format determined by the commissioner, information and documentation that includes,  
563.19 but is not limited to, the following:

563.20 (1) the personal care assistance provider agency's current contact information including  
563.21 address, telephone number, and e-mail address;

563.22 (2) proof of surety bond coverage for each business location providing services. Upon  
563.23 new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up  
563.24 to and including \$300,000, the provider agency must purchase a surety bond of \$50,000. If  
563.25 the Medicaid revenue in the previous year is over \$300,000, the provider agency must  
563.26 purchase a surety bond of \$100,000. The surety bond must be in a form approved by the  
563.27 commissioner, must be renewed annually, and must allow for recovery of costs and fees in  
563.28 pursuing a claim on the bond;

563.29 (3) proof of fidelity bond coverage in the amount of \$20,000 for each business location  
563.30 providing service;

284.18 Sec. 18. Minnesota Statutes 2018, section 256B.064, subdivision 1a, is amended to read:

284.19 Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose  
284.20 sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse  
284.21 in connection with the provision of medical care to recipients of public assistance; (2) a  
284.22 pattern of presentment of false or duplicate claims or claims for services not medically  
284.23 necessary; (3) a pattern of making false statements of material facts for the purpose of  
284.24 obtaining greater compensation than that to which the vendor is legally entitled; (4)  
284.25 suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access  
284.26 during regular business hours to examine all records necessary to disclose the extent of  
284.27 services provided to program recipients and appropriateness of claims for payment; (6)  
284.28 failure to repay an overpayment or a fine finally established under this section; (7) failure  
284.29 to correct errors in the maintenance of health service or financial records for which a fine  
284.30 was imposed or after issuance of a warning by the commissioner; and (8) any reason for  
284.31 which a vendor could be excluded from participation in the Medicare program under section  
284.32 1128, 1128A, or 1866(b)(2) of the Social Security Act.

285.1 (b) The commissioner may impose sanctions against a pharmacy provider for failure to  
285.2 respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph  
285.3 (h).

285.4 **EFFECTIVE DATE.** This section is effective April 1, 2019.

#### ARTICLE 1:

45.29 Sec. 43. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

45.30 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**  
45.31 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of  
46.1 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in  
46.2 a format determined by the commissioner, information and documentation that includes,  
46.3 but is not limited to, the following:

46.4 (1) the personal care assistance provider agency's current contact information including  
46.5 address, telephone number, and e-mail address;

46.6 (2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid  
46.7 revenue in the previous calendar year is up to and including \$300,000, the provider agency  
46.8 must purchase a surety bond of \$50,000. If the Medicaid revenue in the previous year is  
46.9 over \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety  
46.10 bond must be in a form approved by the commissioner, must be renewed annually, and must  
46.11 allow for recovery of costs and fees in pursuing a claim on the bond;

46.12 (3) proof of fidelity bond coverage in the amount of \$20,000;

563.31 (4) proof of workers' compensation insurance coverage identifying the business location  
 563.32 where personal care assistance services are provided;

564.1 (5) proof of liability insurance coverage identifying the business location where personal  
 564.2 care assistance services are provided and naming the department as a certificate holder;

564.3 ~~(6) a description of the personal care assistance provider agency's organization identifying~~  
 564.4 ~~the names of all owners, managing employees, staff, board of directors, and the affiliations~~  
 564.5 ~~of the directors, owners, or staff to other service providers;~~

564.6 ~~(7)~~ (6) a copy of the personal care assistance provider agency's written policies and  
 564.7 procedures including: hiring of employees; training requirements; service delivery; and  
 564.8 employee and consumer safety including process for notification and resolution of consumer  
 564.9 grievances, identification and prevention of communicable diseases, and employee  
 564.10 misconduct;

564.11 ~~(8)~~ (7) copies of all other forms the personal care assistance provider agency uses in the  
 564.12 course of daily business including, but not limited to:

564.13 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet  
 564.14 varies from the standard time sheet for personal care assistance services approved by the  
 564.15 commissioner, and a letter requesting approval of the personal care assistance provider  
 564.16 agency's nonstandard time sheet;

564.17 (ii) the personal care assistance provider agency's template for the personal care assistance  
 564.18 care plan; and

564.19 (iii) the personal care assistance provider agency's template for the written agreement  
 564.20 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

564.21 ~~(9)~~ (8) a list of all training and classes that the personal care assistance provider agency  
 564.22 requires of its staff providing personal care assistance services;

564.23 ~~(10)~~ (9) documentation that the personal care assistance provider agency and staff have  
 564.24 successfully completed all the training required by this section;

564.25 ~~(11)~~ (10) documentation of the agency's marketing practices;

564.26 ~~(12)~~ (11) disclosure of ownership, leasing, or management of all residential properties  
 564.27 that is used or could be used for providing home care services;

564.28 ~~(13)~~ (12) documentation that the agency will use the following percentages of revenue  
 564.29 generated from the medical assistance rate paid for personal care assistance services for  
 564.30 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal  
 564.31 care assistance choice option and 72.5 percent of revenue from other personal care assistance

46.13 (4) proof of workers' compensation insurance coverage;

46.14 (5) proof of liability insurance;

46.15 (6) a description of the personal care assistance provider agency's organization identifying  
 46.16 the names of all owners, managing employees, staff, board of directors, and the affiliations  
 46.17 of the directors, owners, or staff to other service providers;

46.18 (7) a copy of the personal care assistance provider agency's written policies and  
 46.19 procedures including: hiring of employees; training requirements; service delivery;  
 46.20 identification, prevention, detection, and reporting of fraud or any billing, record-keeping,  
 46.21 or other administrative noncompliance; and employee and consumer safety including process  
 46.22 for notification and resolution of consumer grievances, identification and prevention of  
 46.23 communicable diseases, and employee misconduct;

46.24 (8) copies of all other forms the personal care assistance provider agency uses in the  
 46.25 course of daily business including, but not limited to:

46.26 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet  
 46.27 varies from the standard time sheet for personal care assistance services approved by the  
 46.28 commissioner, and a letter requesting approval of the personal care assistance provider  
 46.29 agency's nonstandard time sheet;

46.30 (ii) the personal care assistance provider agency's template for the personal care assistance  
 46.31 care plan; and

47.1 (iii) the personal care assistance provider agency's template for the written agreement  
 47.2 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

47.3 (9) a list of all training and classes that the personal care assistance provider agency  
 47.4 requires of its staff providing personal care assistance services;

47.5 (10) documentation that the personal care assistance provider agency and staff have  
 47.6 successfully completed all the training required by this section;

47.7 (11) documentation of the agency's marketing practices;

47.8 (12) disclosure of ownership, leasing, or management of all residential properties that  
 47.9 is used or could be used for providing home care services;

47.10 (13) documentation that the agency will use the following percentages of revenue  
 47.11 generated from the medical assistance rate paid for personal care assistance services for  
 47.12 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal  
 47.13 care assistance choice option and 72.5 percent of revenue from other personal care assistance

565.1 providers. The revenue generated by the qualified professional and the reasonable costs  
565.2 associated with the qualified professional shall not be used in making this calculation; ~~and~~

565.3 ~~(14)~~ (13) effective May 15, 2010, documentation that the agency does not burden  
565.4 recipients' free exercise of their right to choose service providers by requiring personal care  
565.5 assistants to sign an agreement not to work with any particular personal care assistance  
565.6 recipient or for another personal care assistance provider agency after leaving the agency  
565.7 and that the agency is not taking action on any such agreements or requirements regardless  
565.8 of the date signed.

565.9 (b) Personal care assistance provider agencies shall provide the information specified  
565.10 in paragraph (a) to the commissioner at the time the personal care assistance provider agency  
565.11 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect  
565.12 the information specified in paragraph (a) from all personal care assistance providers  
565.13 beginning July 1, 2009.

565.14 (c) All personal care assistance provider agencies shall require all employees in  
565.15 management and supervisory positions and owners of the agency who are active in the  
565.16 day-to-day management and operations of the agency to complete mandatory training as  
565.17 determined by the commissioner before submitting an application for enrollment of the  
565.18 agency as a provider. All personal care assistance provider agencies shall also require  
565.19 qualified professionals to complete the training required by subdivision 13 before submitting  
565.20 an application for enrollment of the agency as a provider. Employees in management and  
565.21 supervisory positions and owners who are active in the day-to-day operations of an agency  
565.22 who have completed the required training as an employee with a personal care assistance  
565.23 provider agency do not need to repeat the required training if they are hired by another  
565.24 agency, if they have completed the training within the past three years. By September 1,  
565.25 2010, the required training must be available with meaningful access according to title VI

47.14 providers. The revenue generated by the qualified professional and the reasonable costs  
47.15 associated with the qualified professional shall not be used in making this calculation; ~~and~~

47.16 (14) effective May 15, 2010, documentation that the agency does not burden recipients'  
47.17 free exercise of their right to choose service providers by requiring personal care assistants  
47.18 to sign an agreement not to work with any particular personal care assistance recipient or  
47.19 for another personal care assistance provider agency after leaving the agency and that the  
47.20 agency is not taking action on any such agreements or requirements regardless of the date  
47.21 signed; ~~and~~

47.22 (15) a copy of the personal care assistance provider agency's self-auditing policy and  
47.23 other materials demonstrating the personal care assistance provider agency's internal program  
47.24 integrity procedures.

47.25 (b) Personal care assistance provider agencies enrolling for the first time must also  
47.26 provide, at the time of enrollment as a personal care assistance provider agency in a format  
47.27 determined by the commissioner, information and documentation that includes proof of  
47.28 sufficient initial operating capital to support the infrastructure necessary to allow for ongoing  
47.29 compliance with the requirements of this section. Sufficient operating capital can be  
47.30 demonstrated as follows:

47.31 (1) copies of business bank account statements with at least \$5,000 in cash reserves;

47.32 (2) proof of a cash reserve or business line of credit sufficient to equal three payrolls of  
47.33 the agency's current or projected business; and

48.1 (3) any other manner proscribed by the commissioner.

48.2 (c) Personal care assistance provider agencies shall provide the information specified  
48.3 in paragraph (a) to the commissioner at the time the personal care assistance provider agency  
48.4 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect  
48.5 the information specified in paragraph (a) from all personal care assistance providers  
48.6 beginning July 1, 2009.

48.7 ~~(c)~~ (d) All personal care assistance provider agencies shall require all employees in  
48.8 management and supervisory positions and owners of the agency who are active in the  
48.9 day-to-day management and operations of the agency to complete mandatory training as  
48.10 determined by the commissioner before enrollment of the agency as a provider. Employees  
48.11 in management and supervisory positions and owners who are active in the day-to-day  
48.12 operations of an agency who have completed the required training as an employee with a  
48.13 personal care assistance provider agency do not need to repeat the required training if they  
48.14 are hired by another agency, if they have completed the training within the past three years.  
48.15 By September 1, 2010, the required training must be available with meaningful access  
48.16 according to title VI of the Civil Rights Act and federal regulations adopted under that law  
48.17 or any guidance from the United States Health and Human Services Department. The  
48.18 required training must be available online or by electronic remote connection. The required

565.26 of the Civil Rights Act and federal regulations adopted under that law or any guidance from  
 565.27 the United States Health and Human Services Department. The required training must be  
 565.28 available online or by electronic remote connection. The required training must provide for  
 565.29 competency testing. Personal care assistance provider agency billing staff shall complete  
 565.30 training about personal care assistance program financial management. This training is  
 565.31 effective July 1, 2009. Any personal care assistance provider agency enrolled before that  
 565.32 date shall, if it has not already, complete the provider training within 18 months of July 1,  
 565.33 2009. Any new owners or employees in management and supervisory positions involved  
 565.34 in the day-to-day operations are required to complete mandatory training as a requisite of  
 565.35 working for the agency. Personal care assistance provider agencies certified for participation  
 566.1 in Medicare as home health agencies are exempt from the training required in this  
 566.2 subdivision. When available, Medicare-certified home health agency owners, supervisors,  
 566.3 or managers must successfully complete the competency test.

566.4 (d) All surety bonds, fidelity bonds, workers compensation insurance, and liability  
 566.5 insurance required by this subdivision must be maintained continuously. After initial  
 566.6 enrollment, a provider must submit proof of bonds and required coverages at any time at  
 566.7 the request of the commissioner. Services provided while there are lapses in coverage are  
 566.8 not eligible for payment. Lapses in coverage may result in sanctions, including termination.  
 566.9 The commissioner shall send instructions and a due date to submit the requested information  
 566.10 to the personal care assistance provider agency.

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

48.19 training must provide for competency testing. Personal care assistance provider agency  
 48.20 billing staff shall complete training about personal care assistance program financial  
 48.21 management. This training is effective July 1, 2009. Any personal care assistance provider  
 48.22 agency enrolled before that date shall, if it has not already, complete the provider training  
 48.23 within 18 months of July 1, 2009. Any new owners or employees in management and  
 48.24 supervisory positions involved in the day-to-day operations are required to complete  
 48.25 mandatory training as a requisite of working for the agency. Personal care assistance provider  
 48.26 agencies certified for participation in Medicare as home health agencies are exempt from  
 48.27 the training required in this subdivision. When available, Medicare-certified home health  
 48.28 agency owners, supervisors, or managers must successfully complete the competency test.

48.29 (e) All personal care assistance provider agencies must provide, at the time of revalidation  
 48.30 as a personal care assistance provider agency in a format determined by the commissioner  
 48.31 information and documentation that includes, but is not limited to, the following:

48.32 (1) documentation of the payroll paid for the preceding 12 months or other period as  
 48.33 proscribed by the commissioner; and

48.34 (2) financial statements demonstrating compliance with paragraph (a), clause (13).

## ARTICLE 8:

285.5 Sec. 19. Minnesota Statutes 2018, section 256B.69, subdivision 4, is amended to read:

285.6 Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to determine  
 285.7 when limitation of choice may be implemented in the experimental counties. The criteria  
 285.8 shall ensure that all eligible individuals in the county have continuing access to the full  
 285.9 range of medical assistance services as specified in subdivision 6.

285.10 (b) The commissioner shall exempt the following persons from participation in the  
 285.11 project, in addition to those who do not meet the criteria for limitation of choice:

285.12 (1) persons eligible for medical assistance according to section 256B.055, subdivision  
285.13 1;

285.14 (2) persons eligible for medical assistance due to blindness or disability as determined  
285.15 by the Social Security Administration or the state medical review team, unless:

285.16 (i) they are 65 years of age or older; or

285.17 (ii) they reside in Itasca County or they reside in a county in which the commissioner  
285.18 conducts a pilot project under a waiver granted pursuant to section 1115 of the Social  
285.19 Security Act;

285.20 (3) recipients who currently have private coverage through a health maintenance  
285.21 organization;

285.22 (4) recipients who are eligible for medical assistance by spending down excess income  
285.23 for medical expenses other than the nursing facility per diem expense;

285.24 (5) recipients who receive benefits under the Refugee Assistance Program, established  
285.25 under United States Code, title 8, section 1522(e);

285.26 (6) children who are both determined to be severely emotionally disturbed and receiving  
285.27 case management services according to section 256B.0625, subdivision 20, except children  
285.28 who are eligible for and who decline enrollment in an approved preferred integrated network  
285.29 under section 245.4682;

285.30 (7) adults who are both determined to be seriously and persistently mentally ill and  
285.31 received case management services according to section 256B.0625, subdivision 20;

286.1 (8) persons eligible for medical assistance according to section 256B.057, subdivision  
286.2 10; and

286.3 (9) persons with access to cost-effective employer-sponsored private health insurance  
286.4 or persons enrolled in a non-Medicare individual health plan determined to be cost-effective  
286.5 according to section 256B.0625, subdivision 15; and

286.6 (10) persons who are absent from the state for more than 30 consecutive days but still  
286.7 deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision  
286.8 1, paragraph (b).

286.9 Children under age 21 who are in foster placement may enroll in the project on an elective  
286.10 basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective  
286.11 basis. The commissioner may enroll recipients in the prepaid medical assistance program  
286.12 for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending  
286.13 down excess income.

286.14 (c) The commissioner may allow persons with a one-month spenddown who are otherwise  
286.15 eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly  
286.16 spenddown to the state.

286.17 (d) The commissioner may require those individuals to enroll in the prepaid medical  
286.18 assistance program who otherwise would have been excluded under paragraph (b), clauses  
286.19 (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

286.20 (e) Before limitation of choice is implemented, eligible individuals shall be notified and  
286.21 after notification, shall be allowed to choose only among demonstration providers. The  
286.22 commissioner may assign an individual with private coverage through a health maintenance  
286.23 organization, to the same health maintenance organization for medical assistance coverage,  
286.24 if the health maintenance organization is under contract for medical assistance in the  
286.25 individual's county of residence. After initially choosing a provider, the recipient is allowed  
286.26 to change that choice only at specified times as allowed by the commissioner. If a  
286.27 demonstration provider ends participation in the project for any reason, a recipient enrolled  
286.28 with that provider must select a new provider but may change providers without cause once  
286.29 more within the first 60 days after enrollment with the second provider.

286.30 (f) An infant born to a woman who is eligible for and receiving medical assistance and  
286.31 who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to  
286.32 the month of birth in the same managed care plan as the mother once the child is enrolled  
286.33 in medical assistance unless the child is determined to be excluded from enrollment in a  
286.34 prepaid plan under this section.

287.1 Sec. 20. Minnesota Statutes 2018, section 256B.69, subdivision 31, is amended to read:

287.2 Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner  
287.3 shall reduce payments and limit future rate increases paid to managed care plans and  
287.4 county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved on a  
287.5 statewide aggregate basis by program. The commissioner may use competitive bidding,  
287.6 payment reductions, or other reductions to achieve the reductions and limits in this  
287.7 subdivision.

287.8 (b) Beginning September 1, 2011, the commissioner shall reduce payments to managed  
287.9 care plans and county-based purchasing plans as follows:

287.10 (1) 2.0 percent for medical assistance elderly basic care. This shall not apply to Medicare  
287.11 cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

287.12 (2) 2.82 percent for medical assistance families and children;

287.13 (3) 10.1 percent for medical assistance adults without children; and

287.14 (4) 6.0 percent for MinnesotaCare families and children.

287.15 (c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed care  
287.16 plans and county-based purchasing plans for calendar year 2012 to a percentage of the rates  
287.17 in effect on August 31, 2011, as follows:

287.18 (1) 98 percent for medical assistance elderly basic care. This shall not apply to Medicare  
287.19 cost-sharing, nursing facility, personal care assistance, and elderly waiver services;



- 287.20 (2) 97.18 percent for medical assistance families and children;
- 287.21 (3) 89.9 percent for medical assistance adults without children; and
- 287.22 (4) 94 percent for MinnesotaCare families and children.
- 287.23 (d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit the
- 287.24 maximum annual trend increases to rates paid to managed care plans and county-based
- 287.25 purchasing plans as follows:
- 287.26 (1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare
- 287.27 cost-sharing, nursing facility, personal care assistance, and elderly waiver services;
- 287.28 (2) 5.0 percent for medical assistance special needs basic care;
- 287.29 (3) 2.0 percent for medical assistance families and children;
- 287.30 (4) 3.0 percent for medical assistance adults without children;
- 288.1 (5) 3.0 percent for MinnesotaCare families and children; and
- 288.2 (6) 3.0 percent for MinnesotaCare adults without children.
- 288.3 (e) The commissioner may limit trend increases to less than the maximum. Beginning
- 288.4 July 1, 2014, the commissioner shall limit the maximum annual trend increases to rates paid
- 288.5 to managed care plans and county-based purchasing plans as follows for calendar years
- 288.6 2014 and 2015:
- 288.7 (1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare
- 288.8 cost-sharing, nursing facility, personal care assistance, and elderly waiver services;
- 288.9 (2) 5.0 percent for medical assistance special needs basic care;
- 288.10 (3) 2.0 percent for medical assistance families and children;
- 288.11 (4) 3.0 percent for medical assistance adults without children;
- 288.12 (5) 3.0 percent for MinnesotaCare families and children; and
- 288.13 (6) 4.0 percent for MinnesotaCare adults without children.
- 288.14 (f) The commissioner may limit trend increases to less than the maximum. For calendar
- 288.15 year 2014, the commissioner shall reduce the maximum aggregate trend increases by
- 288.16 \$47,000,000 in state and federal funds to account for the reductions in administrative
- 288.17 expenses in subdivision 5i.
- 288.18 (g) Beginning January 1, 2020, to December 31, 2024, the commissioner shall limit the
- 288.19 maximum annual trend increases to rates paid to managed care plans and county-based
- 288.20 purchasing plans as follows for calendar years 2020, 2021, 2023, and 2024:

566.12 Sec. 38. Minnesota Statutes 2018, section 256B.69, is amended by adding a subdivision  
566.13 to read:

566.14 Subd. 38. **Payment rate transparency.** The commissioner shall compare fee-for-service  
566.15 medical assistance, Medicare, and medical assistance managed care and county-based  
566.16 purchasing plan aggregate payment rates for the most frequently used inpatient hospital,  
566.17 primary care, dental care, physician specialist, obstetrics, mental health, substance use  
566.18 disorder, and home health services using available data. The commissioner shall publish  
566.19 this information on the Department of Human Services website and must update the  
566.20 information annually by October 1. The managed care and county-based purchasing plan  
566.21 aggregate payment data must be expressed as the percentage above or below the  
566.22 fee-for-service payment rate for the categories listed in this subdivision.

566.23 **EFFECTIVE DATE.** This section is effective October 1, 2020.

566.24 Sec. 39. **[256B.758] REIMBURSEMENT FOR DOULA SERVICES.**

566.25 Effective for services provided on or after July 1, 2019, payments for doula services  
566.26 provided by a certified doula shall be \$47 per prenatal or postpartum visit and \$488 for  
566.27 attending and providing doula services at a birth.

566.28 Sec. 40. Minnesota Statutes 2018, section 256B.766, is amended to read:

566.29 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

566.30 (a) Effective for services provided on or after July 1, 2009, total payments for basic care  
566.31 services, shall be reduced by three percent, except that for the period July 1, 2009, through  
567.1 June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance  
567.2 and general assistance medical care programs, prior to third-party liability and spenddown  
567.3 calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services,  
567.4 occupational therapy services, and speech-language pathology and related services as basic  
567.5 care services. The reduction in this paragraph shall apply to physical therapy services,  
567.6 occupational therapy services, and speech-language pathology and related services provided  
567.7 on or after July 1, 2010.

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

288.21 (1) 3.4 percent for medical assistance elderly basic care. This shall not apply to Medicare  
288.22 cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

288.23 (2) 3.4 percent for medical assistance special needs basic care;

288.24 (3) 2.4 percent for medical assistance families and children; and

288.25 (4) 2.4 percent for medical assistance adults without children.

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

567.15 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,  
567.16 total payments for ambulatory surgery centers facility fees, medical supplies and durable  
567.17 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,  
567.18 renal dialysis services, laboratory services, public health nursing services, physical therapy  
567.19 services, occupational therapy services, speech therapy services, eyeglasses not subject to  
567.20 a volume purchase contract, hearing aids not subject to a volume purchase contract, and  
567.21 anesthesia services shall be reduced by three percent from the rates in effect on August 31,  
567.22 2011.

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

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

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

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

568.13 (i) Effective for services provided on or after July 1, 2015, the following categories of  
568.14 medical supplies and durable medical equipment shall be individually priced items: enteral  
568.15 nutrition and supplies, customized and other specialized tracheostomy tubes and supplies,  
568.16 electric patient lifts, and durable medical equipment repair and service. This paragraph does  
568.17 not apply to medical supplies and durable medical equipment subject to a volume purchase  
568.18 contract, products subject to the preferred diabetic testing supply program, and items provided

568.19 to dually eligible recipients when Medicare is the primary payer for the item. The  
 568.20 commissioner shall not apply any medical assistance rate reductions to durable medical  
 568.21 equipment as a result of Medicare competitive bidding.

568.22 (j) Effective for services provided on or after July 1, 2015, medical assistance payment  
 568.23 rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased  
 568.24 as follows:

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

568.28 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on  
 568.29 the medical assistance fee schedule, whether or not subject to the Medicare competitive bid  
 568.30 that took effect in January of 2009, shall be increased by 2.94 percent, with this increase  
 568.31 being applied after calculation of any increased payment rate under clause (1).

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

569.4 (k) Effective for nonpressure support ventilators provided on or after January 1, 2016,  
 569.5 the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective  
 569.6 for pressure support ventilators provided on or after January 1, 2016, the rate shall be the  
 569.7 lower of the submitted charge or 47 percent above the Medicare fee schedule rate. For  
 569.8 payments made in accordance with this paragraph, if, and to the extent that, the commissioner  
 569.9 identifies that the state has received federal financial participation for ventilators in excess  
 569.10 of the amount allowed effective January 1, 2018, under United States Code, title 42, section  
 569.11 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and  
 569.12 Medicaid Services with state funds and maintain the full payment rate under this paragraph.

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

569.17 **EFFECTIVE DATE.** This section is effective July 1, 2019, subject to federal approval.  
 569.18 The commissioner shall notify the revisor of statutes when federal approval has been  
 569.19 obtained.

569.20 Sec. 41. Minnesota Statutes 2018, section 256B.79, subdivision 2, is amended to read:

569.21 Subd. 2. **Pilot Grant program established.** The commissioner shall implement a ~~pilot~~  
 569.22 grant program to improve birth outcomes and strengthen early parental resilience for pregnant

569.23 women who are medical assistance enrollees, are at significantly elevated risk for adverse  
569.24 outcomes of pregnancy, and are in targeted populations. The program must promote the  
569.25 provision of integrated care and enhanced services to these pregnant women, including  
569.26 postpartum coordination to ensure ongoing continuity of care, by qualified integrated  
569.27 perinatal care collaboratives.

569.28 Sec. 42. Minnesota Statutes 2018, section 256B.79, subdivision 3, is amended to read:

569.29 Subd. 3. **Grant awards.** The commissioner shall award grants to qualifying applicants  
569.30 to support interdisciplinary, integrated perinatal care. ~~Grants must be awarded beginning~~  
569.31 ~~July 1, 2016.~~ Grant funds must be distributed through a request for proposals process to a  
569.32 designated lead agency within an entity that has been determined to be a qualified integrated  
569.33 perinatal care collaborative or within an entity in the process of meeting the qualifications  
570.1 to become a qualified integrated perinatal care collaborative, and priority shall be given to  
570.2 qualified integrated perinatal care collaboratives that received grants under this section prior  
570.3 to January 1, 2019. Grant awards must be used to support interdisciplinary, team-based  
570.4 needs assessments, planning, and implementation of integrated care and enhanced services  
570.5 for targeted populations. In determining grant award amounts, the commissioner shall  
570.6 consider the identified health and social risks linked to adverse outcomes and attributed to  
570.7 enrollees within the identified targeted population.

570.8 Sec. 43. Minnesota Statutes 2018, section 256B.79, subdivision 4, is amended to read:

570.9 Subd. 4. **Eligibility for grants.** To be eligible for a grant under this section, an entity  
570.10 ~~must show that the entity meets or is in the process of meeting~~ meet qualifications established  
570.11 by the commissioner to be a qualified integrated perinatal care collaborative. These  
570.12 qualifications must include evidence that the entity has ~~or is in the process of developing~~  
570.13 policies, services, and partnerships to support interdisciplinary, integrated care. The policies,  
570.14 services, and partnerships must meet specific criteria and be approved by the commissioner.  
570.15 The commissioner shall ~~establish a process to~~ review the collaborative's capacity for  
570.16 interdisciplinary, integrated care, to be reviewed at the commissioner's discretion. In  
570.17 determining whether the entity meets the qualifications for a qualified integrated perinatal  
570.18 care collaborative, the commissioner shall verify and review whether the entity's policies,  
570.19 services, and partnerships:

570.20 (1) optimize early identification of drug and alcohol dependency and abuse during  
570.21 pregnancy, effectively coordinate referrals and follow-up of identified patients to  
570.22 evidence-based or evidence-informed treatment, and integrate perinatal care services with  
570.23 behavioral health and substance abuse services;

570.24 (2) enhance access to, and effective use of, needed health care or tribal health care  
570.25 services, public health or tribal public health services, social services, mental health services,  
570.26 chemical dependency services, or services provided by community-based providers by  
570.27 bridging cultural gaps within systems of care and by integrating community-based  
570.28 paraprofessionals such as doulas and community health workers as routinely available  
570.29 service components;

570.30 (3) encourage patient education about prenatal care, birthing, and postpartum care, and  
 570.31 document how patient education is provided. Patient education may include information  
 570.32 on nutrition, reproductive life planning, breastfeeding, and parenting;

570.33 (4) integrate child welfare case planning with substance abuse treatment planning and  
 570.34 monitoring, as appropriate;

571.1 (5) effectively systematize screening, collaborative care planning, referrals, and follow  
 571.2 up for behavioral and social risks known to be associated with adverse outcomes and known  
 571.3 to be prevalent within the targeted populations;

571.4 (6) facilitate ongoing continuity of care to include postpartum coordination and referrals  
 571.5 for interconception care, continued treatment for substance abuse, identification and referrals  
 571.6 for maternal depression and other chronic mental health conditions, continued medication  
 571.7 management for chronic diseases, and appropriate referrals to tribal or county-based social  
 571.8 services agencies and tribal or county-based public health nursing services; and

571.9 (7) implement ongoing quality improvement activities as determined by the commissioner,  
 571.10 including collection and use of data from qualified providers on metrics of quality such as  
 571.11 health outcomes and processes of care, and the use of other data that has been collected by  
 571.12 the commissioner.

571.13 Sec. 44. Minnesota Statutes 2018, section 256B.79, subdivision 5, is amended to read:

571.14 Subd. 5. **Gaps in communication, support, and care.** A collaborative receiving a grant  
 571.15 under this section must ~~develop means of identifying and reporting~~ identify and report gaps  
 571.16 in the collaborative's communication, administrative support, and direct care, if any, that  
 571.17 must be remedied for the collaborative to continue to effectively provide integrated care  
 571.18 and enhanced services to targeted populations.

571.19 Sec. 45. Minnesota Statutes 2018, section 256B.79, subdivision 6, is amended to read:

571.20 Subd. 6. **Report.** By January 31, ~~2019~~ 2021, and every two years thereafter, the  
 571.21 commissioner shall report to the chairs and ranking minority members of the legislative  
 571.22 committees with jurisdiction over health and human services policy and finance on the  
 571.23 status and ~~progress outcomes~~ of the ~~pilot~~ grant program. The report must:

571.24 (1) describe the capacity of collaboratives receiving grants under this section;

571.25 (2) contain aggregate information about enrollees served within targeted populations;

571.26 (3) describe the utilization of enhanced prenatal services;

571.27 (4) for enrollees identified with maternal substance use disorders, describe the utilization  
 571.28 of substance use treatment and dispositions of any child protection cases;

571.29 (5) contain data on outcomes within targeted populations and compare these outcomes  
 571.30 to outcomes statewide, using standard categories of race and ethnicity; and

572.1 (6) include recommendations for continuing the program or sustaining improvements  
572.2 through other means beyond June 30, 2019.

288.26 Sec. 21. **[256B.86] PRESCRIBED PEDIATRIC EXTENDED CARE (PPEC) CENTER**  
288.27 **SERVICES.**

288.28 Subdivision 1. **Reimbursement rates.** The daily per-child payment rates for PPEC basic  
288.29 services covered by medical assistance and provided at PPEC centers licensed under chapter  
288.30 144H are:

289.1 (1) for intense complexity: \$550 for four or more hours and \$275 for less than four hours;

289.2 (2) for high complexity: \$450 for four or more hours and \$225 for less than four hours;

289.3 and

289.4 (3) for moderate complexity: \$400 for four or more hours and \$200 for less than four  
289.5 hours.

289.6 Subd. 2. **Determination of complexity level.** Complexity level shall be determined  
289.7 based on the level of nursing intervention required for each child using an assessment tool  
289.8 approved by the commissioner.

289.9 **EFFECTIVE DATE.** This section is effective July 1, 2020, or upon federal approval,  
289.10 whichever occurs later. The commissioner of human services shall notify the revisor of  
289.11 statutes when federal approval is obtained.

ARTICLE 1:

63.1 Sec. 62. Minnesota Statutes 2018, section 256L.01, subdivision 5, is amended to read:

63.2 Subd. 5. **Income.** "Income" has the meaning given for modified adjusted gross income,  
63.3 as defined in Code of Federal Regulations, title 26, section 1.36B-1, and means a household's  
63.4 current income, or if income fluctuates month to month, the income for the 12-month  
63.5 eligibility period. Income includes amounts deposited into checking and savings accounts  
63.6 for personal expenses including rent, mortgage, automobile-related expenses, utilities, and  
63.7 food.

ARTICLE 8:

289.12 Sec. 22. Minnesota Statutes 2018, section 256L.03, subdivision 5, is amended to read:

289.13 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to  
289.14 children under the age of 21 and to American Indians as defined in Code of Federal  
289.15 Regulations, title 42, section 600.5.

289.16 (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered  
289.17 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent  
289.18 for families or individuals with incomes equal to or below 150 percent of the federal poverty



572.3       Sec. 46. Minnesota Statutes 2018, section 256L.11, subdivision 2, is amended to read:

572.4           Subd. 2. **Payment of certain providers.** Services provided by federally qualified health  
572.5 centers, rural health clinics, ~~and~~ facilities of the Indian health service, and certified  
572.6 community behavioral health clinics shall be paid for according to the same rates and  
572.7 conditions applicable to the same service provided by providers that are not federally  
572.8 qualified health centers, rural health clinics, ~~or~~ facilities of the Indian health service, or  
572.9 certified community behavioral health clinics. The alternative payment methodology  
572.10 described under section 256B.0625, subdivision 30, paragraph (l), shall not apply to services  
572.11 delivered under this chapter by federally qualified health centers, rural health clinics, and  
572.12 facilities of the Indian Health Services. The prospective payment system for certified  
572.13 behavioral health clinics under section 256B.0625, subdivision 5m, shall not apply to services  
572.14 delivered under this chapter.

572.15       Sec. 47. Minnesota Statutes 2018, section 295.52, subdivision 8, is amended to read:

572.16           Subd. 8. **Contingent reduction in tax rate.** (a) By December 1 of each year, beginning  
572.17 in 2011, the commissioner of management and budget shall determine the projected balance  
572.18 in the health care access fund for the biennium.

572.19           (b) If the commissioner of management and budget determines that the projected balance  
572.20 in the health care access fund for the biennium reflects a ratio of revenues to expenditures  
572.21 and transfers greater than 125 percent, and if the actual cash balance in the fund is adequate,  
572.22 as determined by the commissioner of management and budget, the commissioner, in  
572.23 consultation with the commissioner of revenue, shall reduce the tax rates levied under  
572.24 subdivisions 1, 1a, 2, 3, and 4, for the subsequent calendar year sufficient to reduce the  
572.25 structural balance in the fund. The rate may be reduced to the extent that the projected

289.19 guidelines; and to 87 percent for families or individuals with incomes that are above 150  
289.20 percent of the federal poverty guidelines and equal to or less than 200 percent of the federal  
289.21 poverty guidelines for the applicable family size. The cost-sharing changes described in  
289.22 this paragraph do not apply to eligible recipients or services exempt from cost-sharing under  
289.23 state law. The cost-sharing changes described in this paragraph shall not be implemented  
289.24 prior to January 1, 2016.

289.25           (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements  
289.26 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,  
289.27 title 42, sections 600.510 and 600.520.

289.28       Sec. 23. Minnesota Statutes 2018, section 256L.03, is amended by adding a subdivision  
289.29 to read:

289.30           Subd. 7. **Minnesota EHB Benchmark Plan.** Notwithstanding subdivisions 1, 2, 3, 3a,  
289.31 and 3b, and section 256L.12, or any other law to the contrary, the services covered for  
289.32 parents, caretakers, foster parents, or legal guardians and single adults without children  
290.1 eligible for MinnesotaCare under section 256L.04 shall be the services covered under the  
290.2 Minnesota EHB Benchmark Plan for plan year 2016 or the actuarial equivalent.

572.26 revenues for the biennium do not exceed 125 percent of expenditures and transfers. The  
572.27 new rate shall be rounded to the nearest one-tenth of one percent. The rate reduction under  
572.28 this paragraph expires at the end of each calendar year and is subject to an annual  
572.29 redetermination by the commissioner of management and budget.

572.30 (c) For purposes of the analysis defined in paragraph (b), the commissioner of  
572.31 management and budget shall include projected revenues, ~~notwithstanding the repeal of the~~  
572.32 ~~tax imposed under this section effective January 1, 2020.~~

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

573.1 Sec. 48. Minnesota Statutes 2018, section 325F.69, is amended by adding a subdivision  
573.2 to read:

573.3 Subd. 7. **Advertisement and sales; misrepresentation of conversion therapy.** No  
573.4 person or entity shall, while conducting any trade or commerce, use or employ any fraud,  
573.5 false pretense, false promise, false guarantee, misrepresentation, false or misleading  
573.6 statements, or deceptive practice when advertising or otherwise offering conversion therapy  
573.7 services. For purposes of this subdivision, "conversion therapy" means services or products  
573.8 that are intended to change an individual's sexual orientation or gender identity, including  
573.9 efforts to change behaviors and gender expressions or to eliminate or reduce sexual or  
573.10 romantic attractions or feelings toward individuals of the same gender.

573.11 Sec. 49. Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision  
573.12 6, as amended by Laws 2004, chapter 272, article 2, section 4; Laws 2005, First Special  
573.13 Session chapter 4, article 5, section 18; and Laws 2005, First Special Session chapter 4,  
573.14 article 9, section 11, is amended to read:

573.15 Subd. 6. **Basic Health Care Grants**

573.16	Summary by Fund		
573.17	General	1,290,454,000	1,475,996,000
573.18	Health Care Access	254,121,000	282,689,000

573.19 **UPDATING FEDERAL POVERTY**  
573.20 **GUIDELINES.** Annual updates to the federal  
573.21 poverty guidelines are effective each July 1,  
573.22 following publication by the United States  
573.23 Department of Health and Human Services  
573.24 for health care programs under Minnesota  
573.25 Statutes, chapters 256, 256B, 256D, and 256L.

573.26 The amounts that may be spent from this  
573.27 appropriation for each purpose are as follows:

573.28 (a) MinnesotaCare Grants

573.29 Health Care Access            253,371,000        281,939,000

573.30 **MINNESOTACARE FEDERAL**

573.31 **RECEIPTS.** Receipts received as a result of

573.32 federal participation pertaining to

573.33 administrative costs of the Minnesota health

574.1 care reform waiver shall be deposited as

574.2 nondedicated revenue in the health care access

574.3 fund. Receipts received as a result of federal

574.4 participation pertaining to grants shall be

574.5 deposited in the federal fund and shall offset

574.6 health care access funds for payments to

574.7 providers.

574.8 **MINNESOTACARE FUNDING.** The

574.9 commissioner may expend money

574.10 appropriated from the health care access fund

574.11 for MinnesotaCare in either fiscal year of the

574.12 biennium.

574.13 (b) MA Basic Health Care Grants - Families

574.14 and Children

574.15 General                            427,769,000        489,545,000

574.16 **SERVICES TO PREGNANT WOMEN.**

574.17 The commissioner shall use available federal

574.18 money for the State-Children's Health

574.19 Insurance Program for medical assistance

574.20 services provided to pregnant women who are

574.21 not otherwise eligible for federal financial

574.22 participation beginning in fiscal year 2003.

574.23 This federal money shall be deposited in the

574.24 federal fund and shall offset general funds for

574.25 payments to providers. Notwithstanding

574.26 section 14, this paragraph shall not expire.

574.27 **MANAGED CARE RATE INCREASE. (a)**

574.28 ~~Effective January 1, 2004, the commissioner~~

574.29 ~~of human services shall increase the total~~

574.30 ~~payments to managed care plans under~~

574.31 ~~Minnesota Statutes, section 256B.69, by an~~

574.32 ~~amount equal to the cost increases to the~~

574.33 ~~managed care plans from by the elimination~~  
574.34 ~~of: (1) the exemption from the taxes imposed~~  
575.1 ~~under Minnesota Statutes, section 2971.05,~~  
575.2 ~~subdivision 5, for premiums paid by the state~~  
575.3 ~~for medical assistance, general assistance~~  
575.4 ~~medical care, and the MinnesotaCare program;~~  
575.5 ~~and (2) the exemption of gross revenues~~  
575.6 ~~subject to the taxes imposed under Minnesota~~  
575.7 ~~Statutes, sections 295.50 to 295.57, for~~  
575.8 ~~payments paid by the state for services~~  
575.9 ~~provided under medical assistance, general~~  
575.10 ~~assistance medical care, and the~~  
575.11 ~~MinnesotaCare program. Any increase based~~  
575.12 ~~on clause (2) must be reflected in provider~~  
575.13 ~~rates paid by the managed care plan unless the~~  
575.14 ~~managed care plan is a staff model health plan~~  
575.15 ~~company.~~

575.16 ~~(b) The commissioner of human services shall~~  
575.17 ~~increase by the applicable tax rate in effect~~  
575.18 ~~under Minnesota Statutes, section 295.52, the~~  
575.19 ~~fee for service payments under medical~~  
575.20 ~~assistance, general assistance medical care,~~  
575.21 ~~and the MinnesotaCare program for services~~  
575.22 ~~subject to the hospital, surgical center, or~~  
575.23 ~~health care provider taxes under Minnesota~~  
575.24 ~~Statutes, sections 295.50 to 295.57, effective~~  
575.25 ~~for services rendered on or after January 1,~~  
575.26 ~~2004.~~

575.27 ~~(c) The commissioner of finance shall transfer~~  
575.28 ~~from the health care access fund to the general~~  
575.29 ~~fund the following amounts in the fiscal years~~  
575.30 ~~indicated: 2004, \$16,587,000; 2005,~~  
575.31 ~~\$46,322,000; 2006, \$49,413,000; and 2007,~~  
575.32 ~~\$58,695,000.~~

575.33 ~~(d) Notwithstanding section 14, these~~  
575.34 ~~provisions shall not expire.~~

576.1 ~~(c) MA Basic Health Care Grants - Elderly~~  
576.2 ~~and Disabled~~

576.3 ~~General~~                      ~~610,518,000~~              ~~743,858,000~~

576.4 **DELAY MEDICAL ASSISTANCE**  
576.5 **FEE-FOR-SERVICE - ACUTE CARE.** The  
576.6 following payments in fiscal year 2005 from  
576.7 the Medicaid Management Information  
576.8 System that would otherwise have been made  
576.9 to providers for medical assistance and general  
576.10 assistance medical care services shall be  
576.11 delayed and included in the first payment in  
576.12 fiscal year 2006:  
  
576.13 (1) for hospitals, the last two payments; and  
576.14 (2) for nonhospital providers, the last payment.  
  
576.15 This payment delay shall not include payments  
576.16 to skilled nursing facilities, intermediate care  
576.17 facilities for mental retardation, prepaid health  
576.18 plans, home health agencies, personal care  
576.19 nursing providers, and providers of only  
576.20 waiver services. The provisions of Minnesota  
576.21 Statutes, section 16A.124, shall not apply to  
576.22 these delayed payments. Notwithstanding  
576.23 section 14, this provision shall not expire.  
  
576.24 **DEAF AND HARD-OF-HEARING**  
576.25 **SERVICES.** If, after making reasonable  
576.26 efforts, the service provider for mental health  
576.27 services to persons who are deaf or hearing  
576.28 impaired is not able to earn \$227,000 through  
576.29 participation in medical assistance intensive  
576.30 rehabilitation services in fiscal year 2005, the  
576.31 commissioner shall transfer \$227,000 minus  
576.32 medical assistance earnings achieved by the  
576.33 grantee to deaf and hard-of-hearing grants to  
577.1 enable the provider to continue providing  
577.2 services to eligible persons.  
  
577.3 (d) General Assistance Medical Care Grants  
  
577.4   General                           239,861,000   229,960,000  
  
577.5 (e) Health Care Grants - Other Assistance

577.6	General	3,067,000	3,407,000
577.7	Health Care Access	750,000	750,000
577.8	<b>MINNESOTA PRESCRIPTION DRUG</b>		
577.9	<b>DEDICATED FUND.</b> Of the general fund		
577.10	appropriation, \$284,000 in fiscal year 2005 is		
577.11	appropriated to the commissioner for the		
577.12	prescription drug dedicated fund established		
577.13	under the prescription drug discount program.		
577.14	<b>DENTAL ACCESS GRANTS</b>		
577.15	<b>CARRYOVER AUTHORITY.</b> Any unspent		
577.16	portion of the appropriation from the health		
577.17	care access fund in fiscal years 2002 and 2003		
577.18	for dental access grants under Minnesota		
577.19	Statutes, section 256B.53, shall not cancel but		
577.20	shall be allowed to carry forward to be spent		
577.21	in the biennium beginning July 1, 2003, for		
577.22	these purposes.		
577.23	<b>STOP-LOSS FUND ACCOUNT.</b> The		
577.24	appropriation to the purchasing alliance		
577.25	stop-loss fund account established under		
577.26	Minnesota Statutes, section 256.956,		
577.27	subdivision 2, for fiscal years 2004 and 2005		
577.28	shall only be available for claim		
577.29	reimbursements for qualifying enrollees who		
577.30	are members of purchasing alliances that meet		
577.31	the requirements described under Minnesota		
577.32	Statutes, section 256.956, subdivision 1,		
577.33	paragraph (f), clauses (1), (2), and (3).		
577.34	(f) Prescription Drug Program		
578.1	General	9,239,000	9,226,000
578.2	<b>PRESCRIPTION DRUG ASSISTANCE</b>		
578.3	<b>PROGRAM.</b> Of the general fund		
578.4	appropriation, \$702,000 in fiscal year 2004		
578.5	and \$887,000 in fiscal year 2005 are for the		
578.6	commissioner to establish and administer the		
578.7	prescription drug assistance program through		
578.8	the Minnesota board on aging.		

578.9 **REBATE REVENUE RECAPTURE.** Any  
578.10 funds received by the state from a drug  
578.11 manufacturer due to errors in the  
578.12 pharmaceutical pricing used by the  
578.13 manufacturer in determining the prescription  
578.14 drug rebate are appropriated to the  
578.15 commissioner to augment funding of the  
578.16 prescription drug program established in  
578.17 Minnesota Statutes, section 256.955.

578.18 Sec. 50. **STUDY OF CLINIC COSTS.**

578.19 The commissioner of human services shall conduct a five-year comparative analysis of  
578.20 the actual change in aggregate federally qualified health center (FQHC) and rural health  
578.21 clinic costs versus the CMS FQHC Market Basket inflator using 2017 through 2022 finalized  
578.22 Medicare Cost Reports, CMS 2224-14, and report the findings to the chairs and ranking  
578.23 minority members of the legislative committees with jurisdiction over health and human  
578.24 services policy and finance, by July 1, 2025.

290.3 Sec. 24. **CORRECTIVE PLAN TO ELIMINATE DUPLICATE PERSONAL**  
290.4 **IDENTIFICATION NUMBERS.**

290.5 (a) The commissioner of human services shall design and implement a corrective plan  
290.6 to address the issue of medical assistance enrollees being assigned more than one personal  
290.7 identification number. Any corrections or fixes that are necessary to address this issue are  
290.8 required to be completed by June 30, 2021.

290.9 (b) By February 15, 2020, the commissioner shall submit a report to the chairs and  
290.10 ranking minority members of the legislative committees with jurisdiction over health and  
290.11 human services policy and finance on the progress of the corrective plan required in paragraph  
290.12 (a), including an update on meeting the June 30, 2021, deadline. The report must also include  
290.13 information on:

290.14 (1) the number of medical assistance enrollees who have been assigned two or more  
290.15 personal identification numbers;

290.16 (2) any possible financial effect of enrollees having duplicate personal identification  
290.17 numbers on health care providers and managed care organizations, including the effect on  
290.18 reimbursement rates, meeting withhold requirements, and capitated payments; and

290.19 (3) any effect on federal payments received by the state.

290.20 Sec. 25. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**  
290.21 **QUALITY MEASURES FOR PRESCRIBED PEDIATRIC EXTENDED CARE**  
290.22 **(PPEC) CENTERS.**

290.23 (a) The commissioner of human services, in consultation with community stakeholders  
290.24 as defined by the commissioner and PPEC centers licensed prior to June 30, 2024, shall  
290.25 develop quality measures for PPEC centers, procedures for PPEC centers to report quality  
290.26 measures to the commissioner, and methods for the commissioner to make the results of  
290.27 the quality measures available to the public.

290.28 (b) The commissioner of human services shall submit by February 1, 2024, a report on  
290.29 the topics described in paragraph (a) to the chairs and ranking minority members of the  
290.30 legislative committees with jurisdiction over health and human services.

290.31 **EFFECTIVE DATE.** This section is effective upon the effective date of section 23.

291.1 Sec. 26. **PAIN MANAGEMENT.**

291.2 (a) The Health Services Policy Committee established under Minnesota Statutes, section  
291.3 256B.0625, subdivision 3c, shall evaluate and make recommendations on the integration  
291.4 of nonpharmacologic pain management that are clinically viable and sustainable; reduce or  
291.5 eliminate chronic pain conditions; improve functional status; and prevent addiction and  
291.6 reduce dependence on opiates or other pain medications. The recommendations must be  
291.7 based on best practices for the effective treatment of musculoskeletal pain provided by  
291.8 health practitioners identified in paragraph (b), and covered under medical assistance. Each  
291.9 health practitioner represented under paragraph (b) shall present the minimum best integrated  
291.10 practice recommendations, policies, and scientific evidence for nonpharmacologic treatment  
291.11 options for eliminating pain and improving functional status within their full professional  
291.12 scope. Recommendations for integration of services may include guidance regarding  
291.13 screening for co-occurring behavioral health diagnoses; protocols for communication between  
291.14 all providers treating a unique individual, including protocols for follow-up; and universal  
291.15 mechanisms to assess improvements in functional status.

291.16 (b) In evaluating and making recommendations, the Health Services Policy Committee  
291.17 shall consult and collaborate with the following health practitioners: acupuncture practitioners  
291.18 licensed under Minnesota Statutes, chapter 147B; chiropractors licensed under Minnesota  
291.19 Statutes, sections 148.01 to 148.10; physical therapists licensed under Minnesota Statutes,  
291.20 sections 148.68 to 148.78; occupational therapists licensed under Minnesota Statutes, sections  
291.21 148.6401 to 148.6449; medical and osteopathic physicians licensed under Minnesota Statutes,  
291.22 chapter 147, and advanced practice registered nurses licensed under Minnesota Statutes,  
291.23 sections 148.171 to 148.285, with experience in providing primary care collaboratively  
291.24 within a multidisciplinary team of health care practitioners who employ nonpharmacologic  
291.25 pain therapies; and psychologists licensed under Minnesota Statutes, section 148.907.

291.26 (c) The commissioner shall submit a progress report to the chairs and ranking minority  
291.27 members of the legislative committees with jurisdiction over health and human services



578.25     Sec. 51. **REPEALER.**  
578.26         (a) Minnesota Statutes 2018, sections 256B.0625, subdivision 63; 256B.0659, subdivision  
578.27     22; and 256L.11, subdivision 2a, are repealed.  
578.28         (b) Minnesota Statutes 2018, section 256B.79, subdivision 7, is repealed effective the  
578.29     day following final enactment.  
578.30         (c) Laws 2011, First Special Session chapter 9, article 6, section 97, subdivision 6, is  
578.31     repealed effective the day following final enactment.

291.28     policy and finance by January 15, 2020, and shall report final recommendations by August  
291.29     1, 2020. The final report may also contain recommendations for developing and implementing  
291.30     a pilot program to assess the clinical viability, sustainability, and effectiveness of integrated  
291.31     nonpharmacologic, multidisciplinary treatments for managing musculoskeletal pain and  
291.32     improving functional status.

ARTICLE 1:

68.7         Sec. 66. **DIRECTIONS TO COMMISSIONER; NEMT DRIVER ENROLLMENT**  
68.8     **IMPACT.**  
68.9         By August 1, 2021, the commissioner of human services shall issue a report to the chairs  
68.10     and ranking minority members of the house of representatives and senate committees with  
68.11     jurisdiction over health and human services. The commissioner must include in the report  
68.12     the commissioner's findings regarding the impact of driver enrollment under Minnesota  
68.13     Statutes, section 256B.0625, subdivision 17, paragraph (c), on the program integrity of the  
68.14     nonemergency medical transportation program. The commissioner must include a  
68.15     recommendation, based on the findings in the report, regarding expanding the driver  
68.16     enrollment requirement.  
69.1         Sec. 68. **DIRECTION TO COMMISSIONER; FEDERAL WAIVER FOR MEDICAL**  
69.2     **ASSISTANCE SELF-ATTESTATION REMOVAL.**  
69.3         The commissioner of human services shall seek all necessary federal waivers to  
69.4     implement the removal of the self-attestation when establishing eligibility for medical  
69.5     assistance.

ARTICLE 8:

292.1         Sec. 27. **REPEALER.**  
292.2         Minnesota Statutes 2018, sections 16A.724, subdivision 2; and 256B.0625, subdivision  
292.3     31c, are repealed.  
292.4         **EFFECTIVE DATE.** This section is effective the day following final enactment.