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ARTICLE 1

DEPARTMENT OF HUMAN SERVICES HEALTH CARE PROGRAMS

Section 1. **[62A.002] APPLICABILITY OF CHAPTER.**

Any benefit or coverage mandate included in this chapter does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L.

Sec. 2. Minnesota Statutes 2020, section 62C.01, is amended by adding a subdivision to read:

Subd. 4. **Applicability.** Any benefit or coverage mandate included in this chapter does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L.

Sec. 3. Minnesota Statutes 2020, section 62D.01, is amended by adding a subdivision to read:

Subd. 3. **Applicability.** Any benefit or coverage mandate included in this chapter does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L.

Sec. 4. **[62J.011] APPLICABILITY OF CHAPTER.**

Any benefit or coverage mandate included in this chapter does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L.

Sec. 5. Minnesota Statutes 2020, section 62Q.02, is amended to read:

62Q.02 APPLICABILITY OF CHAPTER.

(a) This chapter applies only to health plans, as defined in section 62Q.01, and not to other types of insurance issued or renewed by health plan companies, unless otherwise specified.

(b) This chapter applies to a health plan company only with respect to health plans, as defined in section 62Q.01, issued or renewed by the health plan company, unless otherwise specified.

(c) If a health plan company issues or renews health plans in other states, this chapter applies only to health plans issued or renewed in this state for Minnesota residents, or to cover a resident of the state, unless otherwise specified.

(d) Any benefit or coverage mandate included in this chapter does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L.

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Sec. 6. Minnesota Statutes 2020, section 174.30, subdivision 3, is amended to read:

Subd. 3. **Other standards; wheelchair securement; protected transport.** (a) A special transportation service that transports individuals occupying wheelchairs is subject to the provisions of sections 299A.11 to 299A.17 concerning wheelchair securement devices. The commissioners of transportation and public safety shall cooperate in the enforcement of this section and sections 299A.11 to 299A.17 so that a single inspection is sufficient to ascertain compliance with sections 299A.11 to 299A.17 and with the standards adopted under this section. Representatives of the Department of Transportation may inspect wheelchair securement devices in vehicles operated by special transportation service providers to determine compliance with sections 299A.11 to 299A.17 and to issue certificates under section 299A.14, subdivision 4.

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

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

Sec. 7. Minnesota Statutes 2020, section 256.01, subdivision 28, is amended to read:

Subd. 28. **Statewide health information exchange.** (a) The commissioner has the authority to join and participate as a member in a legal entity developing and operating a statewide health information exchange or to develop and operate an encounter alerting service that shall meet the following criteria:

(1) the legal entity must meet all constitutional and statutory requirements to allow the commissioner to participate; and

(2) the commissioner or the commissioner's designated representative must have the right to participate in the governance of the legal entity under the same terms and conditions and subject to the same requirements as any other member in the legal entity and in that role shall act to advance state interests and lessen the burdens of government.

(b) Notwithstanding chapter 16C, the commissioner may pay the state's prorated share of development-related expenses of the legal entity retroactively from October 29, 2007, regardless of the date the commissioner joins the legal entity as a member.

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Sec. 8. Minnesota Statutes 2020, section 256.01, subdivision 28, is amended to read:

Subd. 28. **Statewide health information exchange.** (a) The commissioner has the authority to join and participate as a member in a legal entity developing and operating a statewide health information exchange or to develop and operate an encounter alerting service that shall meet the following criteria:

(1) the legal entity must meet all constitutional and statutory requirements to allow the commissioner to participate; and

(2) the commissioner or the commissioner's designated representative must have the right to participate in the governance of the legal entity under the same terms and conditions and subject to the same requirements as any other member in the legal entity and in that role shall act to advance state interests and lessen the burdens of government.

(b) Notwithstanding chapter 16C, the commissioner may pay the state's prorated share of development-related expenses of the legal entity retroactively from October 29, 2007, regardless of the date the commissioner joins the legal entity as a member.

Sec. 9. Minnesota Statutes 2020, section 256.01, is amended by adding a subdivision to read:

Subd. 42. **Expiration of report mandates.** (a) If the submission of a report by the commissioner of human services to the legislature is mandated by statute and the enabling

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Sec. 8. Minnesota Statutes 2020, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according to the following:

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

(2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology under subdivision 25;

(3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation distinct parts as defined by Medicare shall be paid according to the methodology under subdivision 12; and

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

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

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legislation does not include a date for the submission of a final report, the mandate to submit the report shall expire in accordance with this section.

(b) If the mandate requires the submission of an annual report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1,2023. If the mandate requires the submission of a biennial or less frequent report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1, 2024.

(c) Any reporting mandate enacted on or after January 1, 2021 shall expire three years after the date of enactment if the mandate requires the submission of an annual report and shall expire five years after the date of enactment if the mandate requires the submission of a biennial or less frequent report unless the enacting legislation provides for a different expiration date.

(d) The commissioner shall submit a list to the chairs and ranking minority members of the legislative committee with jurisdiction over human services by February 15 of each year, beginning February 15, 2022, of all reports set to expire during the following calendar year in accordance with this section.

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

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

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

(e) For discharges occurring on or after November 1, 2014, the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

(1) for hospitals paid under the DRG methodology, the base year payment rate per admission is standardized by the applicable Medicare wage index and adjusted by the hospital's disproportionate population adjustment;

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

(3) the cost and charge data used to establish hospital payment rates must only reflect inpatient services covered by medical assistance; and

(4) in determining hospital payment rates for discharges occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per discharge shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years. In determining hospital payment rates for discharges in subsequent base years, the per discharge rates shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year or years and the next base year or years. In any year that inpatient claims volume falls below the threshold required to ensure a statically valid sample of claims, the commissioner may combine claims data from two consecutive years to serve as the base year. Years in which inpatient claims volume is reduced or altered due to a pandemic or other public health emergency shall not be used as a base year or part of a base year if the base year includes more than one year. Changes in costs between base years shall be measured using the lower of the hospital cost index defined in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per claim. The commissioner shall establish the base year for each rebasing period considering the most recent year or years for which filed Medicare cost reports are available. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments

that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

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

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

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

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

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

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

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

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

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

(6) geographic location.

Sec. 9. Minnesota Statutes 2020, section 256.969, is amended by adding a subdivision to read:

Subd. 2f. **Alternate inpatient payment rate.** Effective January 1, 2022, for a hospital eligible to receive disproportionate share hospital payments under subdivision 9, paragraph (d), clause (6), the commissioner shall reduce the amount calculated under subdivision 9, paragraph (d), clause (6), by 99 percent and compute an alternate inpatient payment rate. The alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to what the hospital would have received for providing fee-for-service inpatient

Sec. 12. Minnesota Statutes 2020, section 256.969, is amended by adding a subdivision to read:

Subd. 2f. **Alternate inpatient payment rate.** Effective January 1, 2022, for a hospital eligible to receive disproportionate share hospital payments under subdivision 9, paragraph (d), clause (6), the commissioner shall reduce the amount calculated under subdivision 9, paragraph (d), clause (6), by 99 percent and compute an alternate inpatient payment rate. The alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to what the hospital would have received for providing fee-for-service inpatient

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services under this section to patients enrolled in medical assistance had the hospital received the entire amount calculated under subdivision 9, paragraph (d), clause (6).

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

Sec. 10. Minnesota Statutes 2020, section 256.969, subdivision 9, is amended to read:

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

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

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

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

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

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

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services under this section to patients enrolled in medical assistance had the hospital received the entire amount calculated under subdivision 9, paragraph (d), clause (6).

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

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

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

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

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

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

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

(e) For the purposes of determining eligibility for the disproportionate share hospital factors in paragraph (d), clauses (1) to (6), the medical assistance utilization rate and discharge thresholds shall be measured using only one year when a two-year base period is used.

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

~~(f)~~ (g) An additional payment adjustment shall be established by the commissioner under this subdivision for a hospital that provides high levels of administering high-cost drugs to enrollees in fee-for-service medical assistance. The commissioner shall consider factors including fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, or if the hospital qualifies for the alternative payment rate described in subdivision 2e, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed ~~$1,500,000~~ $9,750,000 in fiscal year 2023 and $14,000,000 per year beginning July 1, 2023.

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EFFECTIVE DATE. This section is effective July 1, 2021, except that the amendment to paragraph (g) is effective January 1, 2023.

Sec. 11. Minnesota Statutes 2020, section 256.9695, subdivision 1, is amended to read:

Subdivision 1. **Appeals.** A hospital may appeal a decision arising from the application of standards or methods under section 256.9685, 256.9686, or 256.969, if an appeal would result in a change to the hospital's payment rate or payments. Both overpayments and underpayments that result from the submission of appeals shall be implemented. Regardless of any appeal outcome, relative values, Medicare wage indexes, Medicare cost-to-charge ratios, and policy adjusters shall not be changed. The appeal shall be heard by an administrative law judge according to sections 14.57 to 14.62, or upon agreement by both parties, according to a modified appeals procedure established by the commissioner and the Office of Administrative Hearings. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

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

Sec. 12. Minnesota Statutes 2020, section 256.983, is amended to read:

256.983 FRAUD PREVENTION INVESTIGATIONS.

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

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

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Sec. 13. Minnesota Statutes 2020, section 256.9695, subdivision 1, is amended to read:

Subdivision 1. **Appeals.** A hospital may appeal a decision arising from the application of standards or methods under section 256.9685, 256.9686, or 256.969, if an appeal would result in a change to the hospital's payment rate or payments. Both overpayments and underpayments that result from the submission of appeals shall be implemented. Regardless of any appeal outcome, relative values, Medicare wage indexes, Medicare cost-to-charge ratios, and policy adjusters shall not be changed. The appeal shall be heard by an administrative law judge according to sections 14.57 to 14.62, or upon agreement by both parties, according to a modified appeals procedure established by the commissioner and the Office of Administrative Hearings. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

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

Sec. 14. Minnesota Statutes 2020, section 256.983, is amended to read:

256.983 FRAUD PREVENTION INVESTIGATIONS.

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

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

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be approved, to include any changes directed or negotiated by the commissioner, no later than June 30 of each year.

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

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

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

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

(b) If, upon investigation, a preponderance of evidence shows a provider committed an intentional program violation, intentionally gave the county or tribe materially false information on the provider's billing forms, provided false attendance records to a county, tribe, or the commissioner, or committed financial misconduct as described in section 245E.01, subdivision 8, the county or tribal agency may suspend a provider's payment pursuant to chapter 245E, or deny or revoke a provider's authorization pursuant to section 119B.13, subdivision 6, paragraph (d), clause (2), prior to pursuing other available remedies.

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be approved, to include any changes directed or negotiated by the commissioner, no later than June 30 of each year.

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

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

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

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

(b) If, upon investigation, a preponderance of evidence shows a provider committed an intentional program violation, intentionally gave the county or tribe materially false information on the provider's billing forms, provided false attendance records to a county, tribe, or the commissioner, or committed financial misconduct as described in section 245E.01, subdivision 8, the county or tribal agency may suspend a provider's payment pursuant to chapter 245E, or deny or revoke a provider's authorization pursuant to section 119B.13, subdivision 6, paragraph (d), clause (2), prior to pursuing other available remedies.

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The county or tribe must send notice in accordance with the requirements of section 119B.161, subdivision 2. If a provider's payment is suspended under this section, the payment suspension shall remain in effect until: (1) the commissioner, county, tribe, or a law enforcement authority determines that there is insufficient evidence warranting the action and a county, tribe, or the commissioner does not pursue an additional administrative remedy under chapter 119B or 245E, or section 256.046 or 256.98; or (2) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted.

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

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

Sec. 13. **[256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

(a) Effective January 1, 2023, the commissioner shall contract with a dental administrator to administer dental services for all recipients of medical assistance and MinnesotaCare, including persons enrolled in managed care as described in section 256B.69.

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

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

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

(4) dental claims processing;

(5) coordination of dental care with other services;

(6) management of fraud and abuse;

(7) monitoring access to dental services;

(8) performance measurement;

(9) quality improvement and evaluation; and

(10) management of third-party liability requirements.

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

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The county or tribe must send notice in accordance with the requirements of section 119B.161, subdivision 2. If a provider's payment is suspended under this section, the payment suspension shall remain in effect until: (1) the commissioner, county, tribe, or a law enforcement authority determines that there is insufficient evidence warranting the action and a county, tribe, or the commissioner does not pursue an additional administrative remedy under chapter 119B or 245E, or section 256.046 or 256.98; or (2) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted.

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

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

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

Sec. 14. Minnesota Statutes 2020, section 256B.04, subdivision 12, is amended to read:

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

~~The rules shall provide:~~

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

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

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

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

Sec. 15. Minnesota Statutes 2020, section 256B.04, subdivision 14, is amended to read:

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

(1) eyeglasses;

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

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

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

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

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

(ix) allergen-reducing products as described in section 256B.0625, subdivision 67, paragraph (c) or (d);

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

(6) drugs.

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

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

Sec. 16. Minnesota Statutes 2020, section 256B.055, subdivision 6, is amended to read:

Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid for a pregnant woman who meets the other eligibility criteria of this section and whose unborn child would be eligible as a needy child under subdivision 10 if born and living with the woman. In accordance with Code of Federal Regulations, title 42, section 435.956, the commissioner must accept self-attestation of pregnancy unless the agency has information that is not reasonably compatible with such attestation. For purposes of this subdivision, a woman is considered pregnant for ~~60 days~~ 12 months postpartum.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

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Sec. 15. Minnesota Statutes 2020, section 256B.055, subdivision 6, is amended to read:

Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid for a pregnant woman who meets the other eligibility criteria of this section and whose unborn child would be eligible as a needy child under subdivision 10 if born and living with the woman. In accordance with Code of Federal Regulations, title 42, section 435.956, the commissioner must accept self-attestation of pregnancy unless the agency has information that is not reasonably compatible with such attestation. For purposes of this subdivision, a woman is considered pregnant for ~~60 days~~ six months postpartum.

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

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Sec. 17. Minnesota Statutes 2020, section 256B.056, subdivision 10, is amended to read:

Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the ~~60-day~~ 12-month postpartum period to update their income and asset information and to submit any required income or asset verification.

(b) The commissioner shall determine the eligibility of private-sector health care coverage for infants less than one year of age eligible under section 256B.055, subdivision 10, or 256B.057, subdivision 1, paragraph (c), and shall pay for private-sector coverage if this is determined to be cost-effective.

(c) The commissioner shall verify assets and income for all applicants, and for all recipients upon renewal.

(d) The commissioner shall utilize information obtained through the electronic service established by the secretary of the United States Department of Health and Human Services and other available electronic data sources in Code of Federal Regulations, title 42, sections 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish standards to define when information obtained electronically is reasonably compatible with information provided by applicants and enrollees, including use of self-attestation, to accomplish real-time eligibility determinations and maintain program integrity.

(e) Each person applying for or receiving medical assistance under section 256B.055, subdivision 7, and any other person whose resources are required by law to be disclosed to determine the applicant's or recipient's eligibility must authorize the commissioner to obtain information from financial institutions to identify unreported accounts as required in section 256.01, subdivision 18f. If a person refuses or revokes the authorization, the commissioner may determine that the applicant or recipient is ineligible for medical assistance. For purposes of this paragraph, an authorization to identify unreported accounts meets the requirements of the Right to Financial Privacy Act, United States Code, title 12, chapter 35, and need not be furnished to the financial institution.

(f) County and tribal agencies shall comply with the standards established by the commissioner for appropriate use of the asset verification system specified in section 256.01, subdivision 18f.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

Sec. 18. Minnesota Statutes 2020, section 256B.057, subdivision 3, is amended to read:

Subd. 3. **Qualified Medicare beneficiaries.** (a) A person ~~who is entitled to Part A Medicare benefits, whose income is equal to or less than 100 percent of the federal poverty guidelines, and whose assets are no more than $10,000 for a single individual and $18,000 for a married couple or family of two or more,~~ is eligible for medical assistance

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Sec. 16. Minnesota Statutes 2020, section 256B.056, subdivision 10, is amended to read:

Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the ~~60-day~~ six months postpartum period to update their income and asset information and to submit any required income or asset verification.

(b) The commissioner shall determine the eligibility of private-sector health care coverage for infants less than one year of age eligible under section 256B.055, subdivision 10, or 256B.057, subdivision 1, paragraph (c), and shall pay for private-sector coverage if this is determined to be cost-effective.

(c) The commissioner shall verify assets and income for all applicants, and for all recipients upon renewal.

(d) The commissioner shall utilize information obtained through the electronic service established by the secretary of the United States Department of Health and Human Services and other available electronic data sources in Code of Federal Regulations, title 42, sections 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish standards to define when information obtained electronically is reasonably compatible with information provided by applicants and enrollees, including use of self-attestation, to accomplish real-time eligibility determinations and maintain program integrity.

(e) Each person applying for or receiving medical assistance under section 256B.055, subdivision 7, and any other person whose resources are required by law to be disclosed to determine the applicant's or recipient's eligibility must authorize the commissioner to obtain information from financial institutions to identify unreported accounts as required in section 256.01, subdivision 18f. If a person refuses or revokes the authorization, the commissioner may determine that the applicant or recipient is ineligible for medical assistance. For purposes of this paragraph, an authorization to identify unreported accounts meets the requirements of the Right to Financial Privacy Act, United States Code, title 12, chapter 35, and need not be furnished to the financial institution.

(f) County and tribal agencies shall comply with the standards established by the commissioner for appropriate use of the asset verification system specified in section 256.01, subdivision 18f.

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

Sec. 17. Minnesota Statutes 2020, section 256B.057, subdivision 3, is amended to read:

Subd. 3. **Qualified Medicare beneficiaries.** (a) A person ~~who is entitled to Part A Medicare benefits, whose income is equal to or less than 100 percent of the federal poverty guidelines, and whose assets are no more than $10,000 for a single individual and $18,000 for a married couple or family of two or more,~~ is eligible for medical assistance

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reimbursement of Medicare Part A and Part B premiums, Part A and Part B coinsurance and deductibles, and cost-effective premiums for enrollment with a health maintenance organization or a competitive medical plan under section 1876 of the Social Security Act if:

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

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

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

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

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

Sec. 19. Minnesota Statutes 2020, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

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reimbursement of Medicare Part A and Part B premiums, Part A and Part B coinsurance and deductibles, and cost-effective premiums for enrollment with a health maintenance organization or a competitive medical plan under section 1876 of the Social Security Act if:

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

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

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

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

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

Sec. 18. Minnesota Statutes 2020, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

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(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(1) refugees admitted to the United States according to United States Code, title 8, section 1157;

(2) persons granted asylum according to United States Code, title 8, section 1158;

(3) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(4) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(5) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning July 1, 2010, children and pregnant women who are noncitizens described in paragraph (b) or who are lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation as provided by the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

(e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this subdivision,

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(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(1) refugees admitted to the United States according to United States Code, title 8, section 1157;

(2) persons granted asylum according to United States Code, title 8, section 1158;

(3) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(4) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

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(e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this subdivision,

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a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(f) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition.

(g) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment of an emergency medical condition are limited to the following:

(i) services delivered in an emergency room or by an ambulance service licensed under chapter 144E that are directly related to the treatment of an emergency medical condition;

(ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; and

(iii) follow-up services that are directly related to the original service provided to treat the emergency medical condition and are covered by the global payment made to the provider.

(2) Services for the treatment of emergency medical conditions do not include:

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ transplants, stem cell transplants, and related care;

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

(viii) rehabilitation services;

(ix) physical, occupational, or speech therapy;

(x) transportation services;

(xi) case management;

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a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(f) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition.

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(ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; and

(iii) follow-up services that are directly related to the original service provided to treat the emergency medical condition and are covered by the global payment made to the provider.

(2) Services for the treatment of emergency medical conditions do not include:

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ transplants, stem cell transplants, and related care;

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

(viii) rehabilitation services;

(ix) physical, occupational, or speech therapy;

(x) transportation services;

(xi) case management;

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(xii) prosthetics, orthotics, durable medical equipment, or medical supplies;

(xiii) dental services;

(xiv) hospice care;

(xv) audiology services and hearing aids;

(xvi) podiatry services;

(xvii) chiropractic services;

(xviii) immunizations;

(xix) vision services and eyeglasses;

(xx) waiver services;

(xxi) individualized education programs; or

(xxii) chemical dependency treatment.

(i) Pregnant noncitizens who are ineligible for federally funded medical assistance because of immigration status, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and ~~60 days~~ 12 months postpartum~~, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program~~.

(j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance. The nonprofit center referenced under this paragraph may establish itself as a provider of mental health targeted case management services through a county contract under section 256.0112, subdivision 6. If the nonprofit center is unable to secure a contract with a lead county in its service area, then, notwithstanding the requirements of section 256B.0625, subdivision 20, the commissioner may negotiate a contract with the nonprofit center for provision of mental health targeted case management services. When serving clients who are not the financial responsibility of their contracted lead county, the nonprofit center must gain the concurrence of the county of financial responsibility prior to providing mental health targeted case management services for those clients.

(k) Notwithstanding paragraph (h), clause (2), the following services are covered as emergency medical conditions under paragraph (f) except where coverage is prohibited under federal law for services under clauses (1) and (2):

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(xii) prosthetics, orthotics, durable medical equipment, or medical supplies;

(xiii) dental services;

(xiv) hospice care;

(xv) audiology services and hearing aids;

(xvi) podiatry services;

(xvii) chiropractic services;

(xviii) immunizations;

(xix) vision services and eyeglasses;

(xx) waiver services;

(xxi) individualized education programs; or

(xxii) chemical dependency treatment.

(i) Pregnant noncitizens who are ineligible for federally funded medical assistance because of immigration status, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and ~~60 days~~ six months postpartum~~, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program~~.

(j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance. The nonprofit center referenced under this paragraph may establish itself as a provider of mental health targeted case management services through a county contract under section 256.0112, subdivision 6. If the nonprofit center is unable to secure a contract with a lead county in its service area, then, notwithstanding the requirements of section 256B.0625, subdivision 20, the commissioner may negotiate a contract with the nonprofit center for provision of mental health targeted case management services. When serving clients who are not the financial responsibility of their contracted lead county, the nonprofit center must gain the concurrence of the county of financial responsibility prior to providing mental health targeted case management services for those clients.

(k) Notwithstanding paragraph (h), clause (2), the following services are covered as emergency medical conditions under paragraph (f) except where coverage is prohibited under federal law for services under clauses (1) and (2):

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(1) dialysis services provided in a hospital or freestanding dialysis facility;

(2) surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission and requires surgery, chemotherapy, or radiation treatment; and

(3) kidney transplant if the person has been diagnosed with end stage renal disease, is currently receiving dialysis services, and is a potential candidate for a kidney transplant.

(l) Effective July 1, 2013, recipients of emergency medical assistance under this subdivision are eligible for coverage of the elderly waiver services provided under chapter 256S, and coverage of rehabilitative services provided in a nursing facility. The age limit for elderly waiver services does not apply. In order to qualify for coverage, a recipient of emergency medical assistance is subject to the assessment and reassessment requirements of section 256B.0911. Initial and continued enrollment under this paragraph is subject to the limits of available funding.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

Sec. 20. Minnesota Statutes 2020, section 256B.0625, subdivision 3c, is amended to read:

Subd. 3c. **Health Services ~~Policy Committee~~ Advisory Council.** (a) The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a ~~13-member~~ 14-member Health Services ~~Policy Committee~~ Advisory Council, which consists of ~~12~~ 13 voting members and one nonvoting member. The Health Services ~~Policy Committee~~ Advisory Council shall advise the commissioner regarding (1) health services pertaining to the administration of health care benefits covered under ~~the medical assistance and MinnesotaCare programs~~ Minnesota health care programs (MHCP); and (2) evidence-based decision-making and health care benefit and coverage policies for MHCP. The Health Services Advisory Council shall consider available evidence regarding quality, safety, and cost-effectiveness when advising the commissioner. The Health Services ~~Policy Committee~~ Advisory Council shall meet at least quarterly. The Health Services ~~Policy Committee~~ Advisory Council shall annually ~~elect~~ select a ~~physician~~ chair from among its members~~,~~ who shall work directly with the commissioner's medical director~~,~~ to establish the agenda for each meeting. The Health Services ~~Policy Committee shall also~~ Advisory Council may recommend criteria for verifying centers of excellence for specific aspects of medical care where a specific set of combined services, a volume of patients necessary to maintain a high level of competency, or a specific level of technical capacity is associated with improved health outcomes.

(b) The commissioner shall establish a dental ~~subcommittee~~ subcouncil to operate under the Health Services ~~Policy Committee~~ Advisory Council. The dental ~~subcommittee~~ subcouncil consists of general dentists, dental specialists, safety net providers, dental

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(1) dialysis services provided in a hospital or freestanding dialysis facility;

(2) surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission and requires surgery, chemotherapy, or radiation treatment; and

(3) kidney transplant if the person has been diagnosed with end stage renal disease, is currently receiving dialysis services, and is a potential candidate for a kidney transplant.

(l) Effective July 1, 2013, recipients of emergency medical assistance under this subdivision are eligible for coverage of the elderly waiver services provided under chapter 256S, and coverage of rehabilitative services provided in a nursing facility. The age limit for elderly waiver services does not apply. In order to qualify for coverage, a recipient of emergency medical assistance is subject to the assessment and reassessment requirements of section 256B.0911. Initial and continued enrollment under this paragraph is subject to the limits of available funding.

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

Sec. 19. Minnesota Statutes 2020, section 256B.0625, subdivision 3c, is amended to read:

Subd. 3c. **Health Services ~~Policy Committee~~ Advisory Council.** (a) The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a ~~13-member~~ 14-member Health Services ~~Policy Committee~~ Advisory Council, which consists of ~~12~~ 13 voting members and one nonvoting member. The Health Services ~~Policy Committee~~ Advisory Council shall advise the commissioner regarding (1) health services pertaining to the administration of health care benefits covered under ~~the medical assistance and MinnesotaCare programs~~ Minnesota health care programs (MHCP); and (2) evidence-based decision-making and health care benefit and coverage policies for MHCP. The Health Services Advisory Council shall consider available evidence regarding quality, safety, and cost-effectiveness when advising the commissioner. The Health Services ~~Policy Committee~~ Advisory Council shall meet at least quarterly. The Health Services ~~Policy Committee~~ Advisory Council shall annually ~~elect~~ select a ~~physician~~ chair from among its members~~,~~ who shall work directly with the commissioner's medical director~~,~~ to establish the agenda for each meeting. The Health Services ~~Policy Committee shall also~~ Advisory Council may recommend criteria for verifying centers of excellence for specific aspects of medical care where a specific set of combined services, a volume of patients necessary to maintain a high level of competency, or a specific level of technical capacity is associated with improved health outcomes.

(b) The commissioner shall establish a dental ~~subcommittee~~ subcouncil to operate under the Health Services ~~Policy Committee~~ Advisory Council. The dental ~~subcommittee~~ subcouncil consists of general dentists, dental specialists, safety net providers, dental

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hygienists, health plan company and county and public health representatives, health researchers, consumers, and a designee of the commissioner of health. The dental ~~subcommittee~~ subcouncil shall advise the commissioner regarding:

(1) the critical access dental program under section 256B.76, subdivision 4, including but not limited to criteria for designating and terminating critical access dental providers;

(2) any changes to the critical access dental provider program necessary to comply with program expenditure limits;

(3) dental coverage policy based on evidence, quality, continuity of care, and best practices;

(4) the development of dental delivery models; and

(5) dental services to be added or eliminated from subdivision 9, paragraph (b).

~~(c) The Health Services Policy Committee shall study approaches to making provider reimbursement under the medical assistance and MinnesotaCare programs contingent on patient participation in a patient-centered decision-making process, and shall evaluate the impact of these approaches on health care quality, patient satisfaction, and health care costs. The committee shall present findings and recommendations to the commissioner and the legislative committees with jurisdiction over health care by January 15, 2010.~~

~~(d)~~ (c) The Health Services ~~Policy Committee shall~~ Advisory Council may monitor and track the practice patterns of ~~physicians providing services to medical assistance and MinnesotaCare enrollees~~ health care providers who serve MHCP recipients under fee-for-service, managed care, and county-based purchasing. The ~~committee~~ monitoring and tracking shall focus on services or specialties for which there is a high variation in utilization or quality across ~~physicians~~ providers, or which are associated with high medical costs. The commissioner, based upon the findings of the ~~committee~~ Health Services Advisory Council, ~~shall regularly~~ may notify ~~physicians~~ providers whose practice patterns indicate below average quality or higher than average utilization or costs. Managed care and county-based purchasing plans shall provide the commissioner with utilization and cost data necessary to implement this paragraph, and the commissioner shall make ~~this~~ these data available to the ~~committee~~ Health Services Advisory Council.

~~(e) The Health Services Policy Committee shall review caesarean section rates for the fee-for-service medical assistance population. The committee may develop best practices policies related to the minimization of caesarean sections, including but not limited to standards and guidelines for health care providers and health care facilities.~~

Sec. 21. Minnesota Statutes 2020, section 256B.0625, subdivision 3d, is amended to read:

Subd. 3d. **Health Services ~~Policy Committee~~ Advisory Council members.** (a) The Health Services ~~Policy Committee~~ Advisory Council consists of:

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hygienists, health plan company and county and public health representatives, health researchers, consumers, and a designee of the commissioner of health. The dental ~~subcommittee~~ subcouncil shall advise the commissioner regarding:

(1) the critical access dental program under section 256B.76, subdivision 4, including but not limited to criteria for designating and terminating critical access dental providers;

(2) any changes to the critical access dental provider program necessary to comply with program expenditure limits;

(3) dental coverage policy based on evidence, quality, continuity of care, and best practices;

(4) the development of dental delivery models; and

(5) dental services to be added or eliminated from subdivision 9, paragraph (b).

~~(c) The Health Services Policy Committee shall study approaches to making provider reimbursement under the medical assistance and MinnesotaCare programs contingent on patient participation in a patient-centered decision-making process, and shall evaluate the impact of these approaches on health care quality, patient satisfaction, and health care costs. The committee shall present findings and recommendations to the commissioner and the legislative committees with jurisdiction over health care by January 15, 2010.~~

~~(d)~~ (c) The Health Services ~~Policy Committee shall~~ Advisory Council may monitor and track the practice patterns of ~~physicians providing services to medical assistance and MinnesotaCare enrollees~~ health care providers who serve MHCP recipients under fee-for-service, managed care, and county-based purchasing. The ~~committee~~ monitoring and tracking shall focus on services or specialties for which there is a high variation in utilization or quality across ~~physicians~~ providers, or which are associated with high medical costs. The commissioner, based upon the findings of the ~~committee~~ Health Services Advisory Council, ~~shall regularly~~ may notify ~~physicians~~ providers whose practice patterns indicate below average quality or higher than average utilization or costs. Managed care and county-based purchasing plans shall provide the commissioner with utilization and cost data necessary to implement this paragraph, and the commissioner shall make ~~this~~ these data available to the ~~committee~~ Health Services Advisory Council.

~~(e) The Health Services Policy Committee shall review caesarean section rates for the fee-for-service medical assistance population. The committee may develop best practices policies related to the minimization of caesarean sections, including but not limited to standards and guidelines for health care providers and health care facilities.~~

Sec. 20. Minnesota Statutes 2020, section 256B.0625, subdivision 3d, is amended to read:

Subd. 3d. **Health Services ~~Policy Committee~~ Advisory Council members.** (a) The Health Services ~~Policy Committee~~ Advisory Council consists of:

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(1) ~~seven~~ six voting members who are licensed physicians actively engaged in the practice of medicine in Minnesota, ~~one of whom must be actively engaged in the treatment of persons with mental illness, and~~ three of whom must represent health plans currently under contract to serve ~~medical assistance~~ MHCP recipients;

(2) two voting members who are licensed physician specialists actively practicing their specialty in Minnesota;

(3) two voting members who are nonphysician health care professionals licensed or registered in their profession and actively engaged in their practice of their profession in Minnesota;

(4) one voting member who is a health care or mental health professional licensed or registered in the member's profession, actively engaged in the practice of the member's profession in Minnesota, and actively engaged in the treatment of persons with mental illness;

~~(4) one consumer~~ (5) two consumers who shall serve as ~~a~~ voting ~~member~~ members; and

~~(5)~~ (6) the commissioner's medical director who shall serve as a nonvoting member.

(b) Members of the Health Services ~~Policy Committee~~ Advisory Council shall not be employed by the ~~Department of Human Services~~ state of Minnesota, except for the medical director. A quorum shall comprise a simple majority of the voting members. Vacant seats shall not count toward a quorum.

Sec. 22. Minnesota Statutes 2020, section 256B.0625, subdivision 3e, is amended to read:

Subd. 3e. **Health Services ~~Policy Committee~~ Advisory Council terms and compensation.** ~~Committee~~ Members shall serve staggered three-year terms, with one-third of the voting members' terms expiring annually. Members may be reappointed by the commissioner. The commissioner may require more frequent Health Services ~~Policy Committee~~ Advisory Council meetings as needed. An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each ~~committee~~ council member in attendance except the medical director. The Health Services ~~Policy Committee~~ Advisory Council does not expire as provided in section 15.059, subdivision 6.

Sec. 23. Minnesota Statutes 2020, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services. The commissioner shall contract with a dental administrator for the administration of dental services. The contract shall include the administration of dental services for persons enrolled in managed care as described in section 256B.69.

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

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

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(1) ~~seven~~ six voting members who are licensed physicians actively engaged in the practice of medicine in Minnesota, ~~one of whom must be actively engaged in the treatment of persons with mental illness, and~~ three of whom must represent health plans currently under contract to serve ~~medical assistance~~ MHCP recipients;

(2) two voting members who are licensed physician specialists actively practicing their specialty in Minnesota;

(3) two voting members who are nonphysician health care professionals licensed or registered in their profession and actively engaged in their practice of their profession in Minnesota;

(4) one voting member who is a health care or mental health professional licensed or registered in the member's profession, actively engaged in the practice of the member's profession in Minnesota, and actively engaged in the treatment of persons with mental illness;

~~(4) one consumer~~ (5) two consumers who shall serve as ~~a~~ voting ~~member~~ members; and

~~(5)~~ (6) the commissioner's medical director who shall serve as a nonvoting member.

(b) Members of the Health Services ~~Policy Committee~~ Advisory Council shall not be employed by the ~~Department of Human Services~~ state of Minnesota, except for the medical director. A quorum shall comprise a simple majority of the voting members. Vacant seats shall not count toward a quorum.

Sec. 21. Minnesota Statutes 2020, section 256B.0625, subdivision 3e, is amended to read:

Subd. 3e. **Health Services ~~Policy Committee~~ Advisory Council terms and compensation.** ~~Committee~~ Members shall serve staggered three-year terms, with one-third of the voting members' terms expiring annually. Members may be reappointed by the commissioner. The commissioner may require more frequent Health Services ~~Policy Committee~~ Advisory Council meetings as needed. An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each ~~committee~~ council member in attendance except the medical director. The Health Services ~~Policy Committee~~ Advisory Council does not expire as provided in section 15.059, subdivision 6.

Sec. 22. Minnesota Statutes 2020, section 256B.0625, subdivision 9, is amended to read:

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

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

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

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

(3) limited exams;

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

(5) periapical x-rays;

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

(7) prophylaxis, limited to one per year;

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

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

(10) anterior fillings;

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

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

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

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

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

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

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

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

(2) general anesthesia; and

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

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

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

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

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

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

(3) limited exams;

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

(5) periapical x-rays;

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

(7) prophylaxis, limited to one per year;

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

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

(10) anterior fillings;

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

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

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

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

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

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

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

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

(2) general anesthesia; and

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

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

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2021, except that the amendments to paragraphs (a) and (f) are effective January 1, 2023.

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

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

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

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

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

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

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

Sec. 23. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 9c. **Uniform prior authorization for dental services.** (a) For purposes of this subdivision, "dental benefits administrator" means an organization licensed under chapter 62C or 62D that contracts with a managed care plan or county-based purchasing plan to provide covered dental care services to enrollees of the plan.

(b) By January 1, 2022, the commissioner, in consultation with interested stakeholders, shall develop uniform prior authorization criteria for all dental services requiring prior authorization. The commissioner shall publish a list of the dental services requiring prior authorization and the process for obtaining prior authorization on the department's website. Dental services on the list and the process for obtaining prior authorization approval must be consistent. The commissioner shall require that dental providers, managed care plans, county-based purchasing plans, and dental benefit administrators use the dental services on the list regardless of whether the services are provided through a fee-for-service system or through a prepaid medical assistance program.

(c) Managed care plans and county-based purchasing plans may require prior authorization for additional dental services not on the list described in paragraph (b) if a uniform process for obtaining prior approvals is applied, including a process for

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Sec. 24. Minnesota Statutes 2020, section 256B.0625, subdivision 13, is amended to read:

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

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

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

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reconsideration when a prior approval request is denied that can be utilized by both the patient and the patient's dental provider.

Sec. 24. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 9d. **Uniform credentialing process.** (a) For purposes of this subdivision, "dental benefits administrator" has the meaning given in subdivision 9c.

(b) By January 1, 2022, the commissioner, in consultation with interested stakeholders, shall develop a uniform credentialing process for dental providers. Upon federal approval, the credentialing process must be accepted by all managed care plans, county-based purchasing plans, and dental benefits administrators that contract with the commissioner or subcontract with plans to provide dental services to medical assistance or MinnesotaCare enrollees.

(c) The process developed in this subdivision must include a uniform credentialing application that must be available in electronic format and accessible on the department's website. The process developed under this subdivision must include an option to submit a completed application electronically. The uniform credentialing application must be available to providers for free.

(d) If applicable, a managed care plan, county-based purchasing plan, dental benefits administrator, contractor, or vendor that reviews and approves a credentialing application must notify a provider regarding a deficiency on a submitted credentialing application form no later than 30 business days after receiving the application form from the provider.

Sec. 25. Minnesota Statutes 2020, section 256B.0625, subdivision 13, is amended to read:

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

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

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

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drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

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

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

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

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

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

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies. By March 1 of each year, each 340B covered entity and ambulatory pharmacy under common ownership of the 340B covered entity must report to the commissioner its reimbursements

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drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

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

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

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

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

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

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

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for the previous calendar year from each managed care and county-based purchasing plan, or the pharmacy benefit manager contracted with the managed care or county-based purchasing plan. The report must include:

(1) the National Provider Identification (NPI) number for each 340B covered entity or ambulatory pharmacy under common ownership of the 340B covered entity;

(2) the name of each 340B covered entity;

(3) the servicing address of each 340B covered entity;

(4) the aggregate cost of drugs purchased during the prior calendar year through the 340B program;

(5) the aggregate cost of drugs purchased during the prior calendar year outside of the 340B program;

(6) the total reimbursement received by the 340B covered entity from all payers, including uninsured patients, for all drugs during the prior calendar year; and

(7) either: (i) the number of outpatient 340B pharmacy claims and reimbursement amounts from each managed care and county-based purchasing plan, or pharmacy benefit manager contracted with the managed care or county-based purchasing plan; or (ii) the number of professional or facility 340B claim lines and reimbursement amounts during the prior calendar year from each managed care and county-based purchasing plan.

The commissioner shall submit a copy of the reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by April 1 of each year. Drugs acquired through the federal 340B Drug Pricing Program and dispensed by a 340B covered entity or ambulatory pharmacy under common ownership of the 340B covered entity are not eligible for coverage if the 340B covered entity or ambulatory pharmacy under common ownership of the 340B covered entity fails to submit a report to the commissioner containing the information required under clauses (1) to (7).

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

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

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Sec. 25. Minnesota Statutes 2020, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least twice per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. ~~The Formulary Committee expires June 30, 2022.~~ Notwithstanding section 15.059, subdivision 6, the Formulary Committee does not expire.

Sec. 26. Minnesota Statutes 2020, section 256B.0625, subdivision 13d, is amended to read:

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

(b) The formulary shall not include:

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

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

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

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

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

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Sec. 26. Minnesota Statutes 2020, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least twice per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. The Formulary Committee expires June 30, 2022.

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

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

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

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

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be ~~$10.48~~ $10.77 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be ~~$10.48~~ $10.77 per ~~bag~~ claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be ~~$10.48~~ $10.77 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services

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

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be ~~$10.48~~ $10.77 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be ~~$10.48~~ $10.77 per ~~bag~~ claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be ~~$10.48~~ $10.77 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services

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Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

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

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

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

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

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Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

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

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

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

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

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

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

Sec. 28. Minnesota Statutes 2020, section 256B.0625, subdivision 13g, is amended to read:

Subd. 13g. **Preferred drug list.** (a) The commissioner shall adopt and implement a preferred drug list by January 1, 2004. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred drug list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall publish the preferred drug list annually in the State Register and shall maintain an accurate and up-to-date list on the agency website.

(b) The commissioner may add to, delete from, and otherwise modify the preferred drug list, after consulting with the Formulary Committee and appropriate medical specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred drug list as part of the administration of the supplemental drug rebate program. Reimbursement for prescription drugs not on the preferred drug list may be subject to prior authorization.

(d) For purposes of this subdivision, "preferred drug list" means a list of prescription drugs within designated therapeutic classes selected by the commissioner, for which prior authorization based on the identity of the drug or class is not required.

(e) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

(f) Notwithstanding paragraph (b), before the commissioner may delete a drug from the preferred drug list or modify the inclusion of a drug on the preferred drug list, the commissioner, in consultation with the commissioner of health, shall consider any implications the deletion or modification may have on state public health policies or initiatives and any impact the deletion or modification may have on increasing health disparities in the state. Prior to deleting a drug or modifying the inclusion of a drug, the commissioner shall also conduct a public hearing. The commissioner shall provide adequate notice to the public prior to the hearing that specifies the drug the commissioner is proposing to delete or modify, any medical or clinical analysis that the commissioner has relied on in proposing the deletion or modification, and evidence that the commissioner has consulted with the commissioner of health and has evaluated the impact of the proposed deletion or modification on public health and health disparities.

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

Sec. 29. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13k. **Eligible providers.** (a) To be eligible to dispense prescription drugs under this section as an enrolled dispensing provider, the dispensing provider must be a:

Sec. 28. Minnesota Statutes 2020, section 256B.0625, subdivision 17, is amended to read:

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

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

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

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

(1) pharmacy located within the state that is licensed by the Board of Pharmacy under chapter 151;

(2) physician located in a service area where there is no medical assistance enrolled pharmacy; or

(3) physician or advanced practice registered nurse employed by or under contract with a community health board for communicable disease control.

(b) A licensed out-of-state pharmacy may be enrolled as a dispensing provider under paragraph (a) if the pharmacy is:

(1) a retail pharmacy located within 50 miles of the Minnesota border that serves walk-in medical assistance enrollees and whose walk-in customers represent at least 75 percent of the pharmacy's prescription volume;

(2) a retail pharmacy serving foster children enrolled in medical assistance and living outside of Minnesota;

(3) serving enrollees receiving preapproved organ transplants who require medication during after-care while residing outside of Minnesota; or

(4) providing products with limited or exclusive distribution channels for which there is no potential dispensing provider located within the state.

(c) A dispensing provider must attest that they meet the requirements in paragraphs (a) and (b) before enrolling as a dispensing provider in the medical assistance program. If a provider is found to be out of compliance with the requirements in paragraphs (a) and (b), any funds paid to that provider during the time they were out of compliance shall be recovered under section 256B.064.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(f) Until the commissioner implements the single administrative structure and delivery system under subdivision 18c, clients shall obtain their level-of-service certificate from the~~

~~commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) investigate all complaints and appeals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 29. Minnesota Statutes 2020, section 256B.0625, subdivision 17b, is amended to read:

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

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

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

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

(3) each entry in the record must document:

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

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

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

(iv) the signature of the driver attesting to the following: "I certify that I have accurately reported in this record the trip miles I actually drove and the dates and times I actually drove them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings.";

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

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

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

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

(ix) whether the service was ambulatory or nonambulatory;

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

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

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

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

Sec. 30. Minnesota Statutes 2020, section 256B.0625, subdivision 18, is amended to read:

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

(b) The commissioner may provide a monthly public transit pass to recipients who are well-served by public transit for the recipient's nonemergency medical transportation needs. Any recipient who is eligible for one public transit trip for a medically necessary covered service may select to receive a transit pass for that month. Recipients who do not have any transportation needs for a medically necessary service in any given month or who have received a transit pass for that month through another program administered by a county or Tribe are not eligible for a transit pass that month. The commissioner shall not require recipients to select a monthly transit pass if the recipient's transportation needs cannot be served by public transit systems. Recipients who receive a monthly transit pass are not eligible for other modes of transportation, unless an unexpected need arises that cannot be accessed through public transit.

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

Sec. 31. Minnesota Statutes 2020, section 256B.0625, subdivision 18b, is amended to read:

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

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

Sec. 32. Minnesota Statutes 2020, section 256B.0625, subdivision 30, is amended to read:

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

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. An FQHC that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with

the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

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

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring an FQHC or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) general social services and administrative costs;

(ii) retail pharmacy;

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

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fund-raising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year. Years in which organizational cost or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency shall not be used as part of a base year when the base year includes more than one year. The commissioner may use the Medicare cost reports of a year unaffected by a pandemic, disease, or other public health emergency, or previous two consecutive years, inflated to the base year as established under item (iv);

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 33. Minnesota Statutes 2020, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions

and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

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

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

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

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

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

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in Code of Federal Regulations, title 42, part 440.70.

(h) Allergen-reducing products provided according to subdivision 67, paragraph (c) or (d), shall be considered durable medical equipment.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 34. Minnesota Statutes 2020, section 256B.0625, subdivision 58, is amended to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** (a) Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). In administering the EPSDT program, the commissioner shall, at a minimum:

(1) provide information to children and families, using the most effective mode identified, regarding:

(i) the benefits of preventative health care visits;

(ii) the services available as part of the EPSDT program; and

(iii) assistance finding a provider, transportation, or interpreter services;

(2) maintain an up-to-date periodicity schedule published in the department policy manual, taking into consideration the most up-to-date community standard of care; and

(3) maintain up-to-date policies for providers on the delivery of EPSDT services that are in the provider manual on the department website.

(b) The commissioner may contract for the administration of the outreach services as required within the EPSDT program.

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

(d) The payment amount for a complete EPSDT screening shall not include charges for health care services and products that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

EFFECTIVE DATE. This section is effective July 1, 2021, except that paragraph (c) is effective January 1, 2022.

Sec. 35. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 67. **Enhanced asthma care services.** (a) Medical assistance covers enhanced asthma care services and related products to be provided in the children's homes for children with poorly controlled asthma. To be eligible for services and products under this subdivision, a child must:

(1) have poorly controlled asthma defined by having received health care for the child's asthma from a hospital emergency department at least one time in the past year or have been hospitalized for the treatment of asthma at least one time in the past year; and

(2) receive a referral for services and products under this subdivision from a treating health care provider.

(b) Covered services include home visits provided by a registered environmental health specialist or lead risk assessor currently credentialed by the Department of Health or a healthy homes specialist credentialed by the Building Performance Institute.

(c) Covered products include the following allergen-reducing products that are identified as needed and recommended for the child by a registered environmental health specialist, healthy homes specialist, lead risk assessor, certified asthma educator, public health nurse, or other health care professional providing asthma care for the child, and proven to reduce asthma triggers:

(1) allergen encasements for mattresses, box springs, and pillows;

(2) an allergen-rated vacuum cleaner, filters, and bags;

(3) a dehumidifier and filters;

(4) HEPA single-room air cleaners and filters;

(5) integrated pest management, including traps and starter packages of food storage containers;

(6) a damp mopping system;

(7) if the child does not have access to a bed, a waterproof hospital-grade mattress; and

(8) for homeowners only, furnace filters.

(d) The commissioner shall determine additional products that may be covered as new best practices for asthma care are identified.

(e) A home assessment is a home visit to identify asthma triggers in the home and to provide education on trigger-reducing products. A child is limited to two home assessments except that a child may receive an additional home assessment if the child moves to a new home; if a new asthma trigger, including tobacco smoke, enters the home; or if the child's health care provider identifies a new allergy for the child, including an allergy to mold,

pests, pets, or dust mites. The commissioner shall determine the frequency with which a child may receive a product under paragraph (c) or (d) based on the reasonable expected lifetime of the product.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 36. Minnesota Statutes 2020, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness. No co-payments shall apply to medications when used for the prevention or treatment of the human immunodeficiency virus (HIV);

(4) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; and

(5) total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care

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plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

EFFECTIVE DATE. This section is effective January 1, 2022, subject to federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 37. Minnesota Statutes 2020, section 256B.0638, subdivision 3, is amended to read:

Subd. 3. **Opioid prescribing work group.** (a) The commissioner of human services, in consultation with the commissioner of health, shall appoint the following voting members to an opioid prescribing work group:

(1) two consumer members who have been impacted by an opioid abuse disorder or opioid dependence disorder, either personally or with family members;

(2) one member who is a licensed physician actively practicing in Minnesota and registered as a practitioner with the DEA;

(3) one member who is a licensed pharmacist actively practicing in Minnesota and registered as a practitioner with the DEA;

(4) one member who is a licensed nurse practitioner actively practicing in Minnesota and registered as a practitioner with the DEA;

(5) one member who is a licensed dentist actively practicing in Minnesota and registered as a practitioner with the DEA;

(6) two members who are nonphysician licensed health care professionals actively engaged in the practice of their profession in Minnesota, and their practice includes treating pain;

(7) one member who is a mental health professional who is licensed or registered in a mental health profession, who is actively engaged in the practice of that profession in Minnesota, and whose practice includes treating patients with chemical dependency or substance abuse;

(8) one member who is a medical examiner for a Minnesota county;

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Sec. 31. Minnesota Statutes 2020, section 256B.0638, subdivision 3, is amended to read:

Subd. 3. **Opioid prescribing work group.** (a) The commissioner of human services, in consultation with the commissioner of health, shall appoint the following voting members to an opioid prescribing work group:

(1) two consumer members who have been impacted by an opioid abuse disorder or opioid dependence disorder, either personally or with family members;

(2) one member who is a licensed physician actively practicing in Minnesota and registered as a practitioner with the DEA;

(3) one member who is a licensed pharmacist actively practicing in Minnesota and registered as a practitioner with the DEA;

(4) one member who is a licensed nurse practitioner actively practicing in Minnesota and registered as a practitioner with the DEA;

(5) one member who is a licensed dentist actively practicing in Minnesota and registered as a practitioner with the DEA;

(6) two members who are nonphysician licensed health care professionals actively engaged in the practice of their profession in Minnesota, and their practice includes treating pain;

(7) one member who is a mental health professional who is licensed or registered in a mental health profession, who is actively engaged in the practice of that profession in Minnesota, and whose practice includes treating patients with chemical dependency or substance abuse;

(8) one member who is a medical examiner for a Minnesota county;

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(9) one member of the Health Services Policy Committee established under section 256B.0625, subdivisions 3c to 3e;

(10) one member who is a medical director of a health plan company doing business in Minnesota;

(11) one member who is a pharmacy director of a health plan company doing business in Minnesota; ~~and~~

(12) one member representing Minnesota law enforcement~~.~~; and

(13) two consumer members who are Minnesota residents and who have used or are using opioids to manage chronic pain.

(b) In addition, the work group shall include the following nonvoting members:

(1) the medical director for the medical assistance program;

(2) a member representing the Department of Human Services pharmacy unit; ~~and~~

(3) the medical director for the Department of Labor and Industry~~.~~; and

(4) a member representing the Minnesota Department of Health.

(c) An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each voting member in attendance.

Sec. 38. Minnesota Statutes 2020, section 256B.0638, subdivision 5, is amended to read:

Subd. 5. **Program implementation.** (a) The commissioner shall implement the programs within the Minnesota health care program to improve the health of and quality of care provided to Minnesota health care program enrollees. The commissioner shall annually collect and report to provider groups the sentinel measures of data showing individual opioid ~~prescribers data showing the sentinel measures of their~~ prescribers' opioid prescribing patterns compared to their anonymized peers. Provider groups shall distribute data to their affiliated, contracted, or employed opioid prescribers.

(b) The commissioner shall notify an opioid prescriber and all provider groups with which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber and any provider group that receives a notice under this paragraph shall submit to the commissioner a quality improvement plan for review and approval by the commissioner with the goal of bringing the opioid prescriber's prescribing practices into alignment with community standards. A quality improvement plan must include:

(1) components of the program described in subdivision 4, paragraph (a);

(2) internal practice-based measures to review the prescribing practice of the opioid prescriber and, where appropriate, any other opioid prescribers employed by or affiliated

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(9) one member of the Health Services Policy Committee established under section 256B.0625, subdivisions 3c to 3e;

(10) one member who is a medical director of a health plan company doing business in Minnesota;

(11) one member who is a pharmacy director of a health plan company doing business in Minnesota; ~~and~~

(12) one member representing Minnesota law enforcement~~.~~; and

(13) two consumer members who are Minnesota residents and who have used or are using opioids to manage chronic pain.

(b) In addition, the work group shall include the following nonvoting members:

(1) the medical director for the medical assistance program;

(2) a member representing the Department of Human Services pharmacy unit; ~~and~~

(3) the medical director for the Department of Labor and Industry~~.~~; and

(4) a member representing the Department of Health.

(c) An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each voting member in attendance.

Sec. 32. Minnesota Statutes 2020, section 256B.0638, subdivision 5, is amended to read:

Subd. 5. **Program implementation.** (a) The commissioner shall implement the programs within the Minnesota health care program to improve the health of and quality of care provided to Minnesota health care program enrollees. The commissioner shall annually collect and report to provider groups the sentinel measures of data showing individual opioid ~~prescribers data showing the sentinel measures of their~~ prescribers' opioid prescribing patterns compared to their anonymized peers. Provider groups shall distribute data to their affiliated, contracted, or employed opioid prescribers.

(b) The commissioner shall notify an opioid prescriber and all provider groups with which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber and any provider group that receives a notice under this paragraph shall submit to the commissioner a quality improvement plan for review and approval by the commissioner with the goal of bringing the opioid prescriber's prescribing practices into alignment with community standards. A quality improvement plan must include:

(1) components of the program described in subdivision 4, paragraph (a);

(2) internal practice-based measures to review the prescribing practice of the opioid prescriber and, where appropriate, any other opioid prescribers employed by or affiliated

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with any of the provider groups with which the opioid prescriber is employed or affiliated; and

(3) appropriate use of the prescription monitoring program under section 152.126.

(c) If, after a year from the commissioner's notice under paragraph (b), the opioid prescriber's prescribing practices do not improve so that they are consistent with community standards, the commissioner shall take one or more of the following steps:

(1) monitor prescribing practices more frequently than annually;

(2) monitor more aspects of the opioid prescriber's prescribing practices than the sentinel measures; or

(3) require the opioid prescriber to participate in additional quality improvement efforts, including but not limited to mandatory use of the prescription monitoring program established under section 152.126.

(d) The commissioner shall terminate from Minnesota health care programs all opioid prescribers and provider groups whose prescribing practices fall within the applicable opioid disenrollment standards.

Sec. 39. Minnesota Statutes 2020, section 256B.0638, subdivision 6, is amended to read:

Subd. 6. **Data practices.** (a) Reports and data identifying an opioid prescriber are private data on individuals as defined under section 13.02, subdivision 12, until an opioid prescriber is subject to termination as a medical assistance provider under this section. Notwithstanding this data classification, the commissioner shall share with all of the provider groups with which an opioid prescriber is employed, contracted, or affiliated, ~~a report identifying an opioid prescriber who is subject to quality improvement activities~~ the data under subdivision 5, paragraph (a), (b), or (c).

(b) Reports and data identifying a provider group are nonpublic data as defined under section 13.02, subdivision 9, until the provider group is subject to termination as a medical assistance provider under this section.

(c) Upon termination under this section, reports and data identifying an opioid prescriber or provider group are public, except that any identifying information of Minnesota health care program enrollees must be redacted by the commissioner.

Sec. 40. Minnesota Statutes 2020, section 256B.0659, subdivision 13, is amended to read:

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must work for a personal care assistance provider agency, meet the definition of qualified professional under section 256B.0625, subdivision 19c, ~~and enroll with the department as a qualified professional after clearing~~ clear a background study, and meet provider training requirements. Before a qualified professional provides services, the personal care assistance provider agency must initiate a background study on the qualified professional under chapter

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with any of the provider groups with which the opioid prescriber is employed or affiliated; and

(3) appropriate use of the prescription monitoring program under section 152.126.

(c) If, after a year from the commissioner's notice under paragraph (b), the opioid prescriber's prescribing practices do not improve so that they are consistent with community standards, the commissioner shall take one or more of the following steps:

(1) monitor prescribing practices more frequently than annually;

(2) monitor more aspects of the opioid prescriber's prescribing practices than the sentinel measures; or

(3) require the opioid prescriber to participate in additional quality improvement efforts, including but not limited to mandatory use of the prescription monitoring program established under section 152.126.

(d) The commissioner shall terminate from Minnesota health care programs all opioid prescribers and provider groups whose prescribing practices fall within the applicable opioid disenrollment standards.

Sec. 33. Minnesota Statutes 2020, section 256B.0638, subdivision 6, is amended to read:

Subd. 6. **Data practices.** (a) Reports and data identifying an opioid prescriber are private data on individuals as defined under section 13.02, subdivision 12, until an opioid prescriber is subject to termination as a medical assistance provider under this section. Notwithstanding this data classification, the commissioner shall share with all of the provider groups with which an opioid prescriber is employed, contracted, or affiliated, ~~a report identifying an opioid prescriber who is subject to quality improvement activities~~ the data under subdivision 5, paragraph (a), (b), or (c).

(b) Reports and data identifying a provider group are nonpublic data as defined under section 13.02, subdivision 9, until the provider group is subject to termination as a medical assistance provider under this section.

(c) Upon termination under this section, reports and data identifying an opioid prescriber or provider group are public, except that any identifying information of Minnesota health care program enrollees must be redacted by the commissioner.

Sec. 34. Minnesota Statutes 2020, section 256B.0659, subdivision 13, is amended to read:

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must work for a personal care assistance provider agency, meet the definition of qualified professional under section 256B.0625, subdivision 19c, ~~and enroll with the department as a qualified professional after clearing~~ clear a background study, and meet provider training requirements. Before a qualified professional provides services, the personal care assistance provider agency must initiate a background study on the qualified professional under chapter

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245C, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional:

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

(2) is disqualified, but the qualified professional has received a set aside of the disqualification under section 245C.22.

(b) The qualified professional shall perform the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care assistance services. The qualified professional shall:

(1) develop and monitor with the recipient a personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) develop and monitor with the recipient a monthly plan for the use of personal care assistance services;

(3) review documentation of personal care assistance services provided;

(4) provide training and ensure competency for the personal care assistant in the individual needs of the recipient; and

(5) document all training, communication, evaluations, and needed actions to improve performance of the personal care assistants.

(c) ~~Effective July 1, 2011,~~ The qualified professional shall complete the provider training with basic information about the personal care assistance program approved by the commissioner. Newly hired qualified professionals must complete the training within six months of the date hired by a personal care assistance provider agency. Qualified professionals who have completed the required training as a worker from a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the last three years. The required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing to demonstrate an understanding of the content without attending in-person training. A qualified professional is allowed to be employed and is not subject to the training requirement until the training is offered online or through remote electronic connection. A qualified professional employed by a personal care assistance provider agency certified for participation in Medicare as a home health agency is exempt from the training required in this subdivision. When available, the qualified professional working for a Medicare-certified home health agency must successfully complete the competency test. The commissioner shall ensure there is a mechanism in place to verify the identity of persons completing the competency testing electronically.

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245C, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional:

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

(2) is disqualified, but the qualified professional has received a set aside of the disqualification under section 245C.22.

(b) The qualified professional shall perform the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care assistance services. The qualified professional shall:

(1) develop and monitor with the recipient a personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) develop and monitor with the recipient a monthly plan for the use of personal care assistance services;

(3) review documentation of personal care assistance services provided;

(4) provide training and ensure competency for the personal care assistant in the individual needs of the recipient; and

(5) document all training, communication, evaluations, and needed actions to improve performance of the personal care assistants.

(c) ~~Effective July 1, 2011,~~ The qualified professional shall complete the provider training with basic information about the personal care assistance program approved by the commissioner. Newly hired qualified professionals must complete the training within six months of the date hired by a personal care assistance provider agency. Qualified professionals who have completed the required training as a worker from a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the last three years. The required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing to demonstrate an understanding of the content without attending in-person training. A qualified professional is allowed to be employed and is not subject to the training requirement until the training is offered online or through remote electronic connection. A qualified professional employed by a personal care assistance provider agency certified for participation in Medicare as a home health agency is exempt from the training required in this subdivision. When available, the qualified professional working for a Medicare-certified home health agency must successfully complete the competency test. The commissioner shall ensure there is a mechanism in place to verify the identity of persons completing the competency testing electronically.

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Sec. 41. Minnesota Statutes 2020, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, ~~Hennepin County and~~ Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed ~~$12,000,000 per year from Hennepin County and~~ $6,000,000 per year ~~from Ramsey County~~. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced

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Sec. 37. Minnesota Statutes 2020, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, ~~Hennepin County and~~ Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed ~~$12,000,000 per year from Hennepin County and~~ $6,000,000 per year ~~from Ramsey County~~. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced

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payments to ~~Hennepin County Medical Center or~~ Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to ~~Hennepin County Medical Center and~~ Regions Hospital by those plans. For the purposes of this paragraph, "the base amount" means the total annual value of increased medical assistance capitation payments, including the voluntary intergovernmental transfers, under this paragraph in calendar year 2017. For managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance capitation payments under this paragraph by an amount equal to ten percent of the base amount, and by an additional ten percent of the base amount for each subsequent contract year until December 31, 2025. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to ~~Hennepin County Medical Center and~~ Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph. This paragraph expires January 1, 2026.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul, and ambulance services owned and operated by another governmental entity that chooses to participate by requesting the commissioner to determine an upper payment limit. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County, the city of St. Paul, and other participating governmental entities of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities. A tribal government that owns and operates an ambulance service is not eligible to participate under this subdivision.

(e) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform the University of Minnesota Medical School and University of

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payments to ~~Hennepin County Medical Center or~~ Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to ~~Hennepin County Medical Center and~~ Regions Hospital by those plans. For the purposes of this paragraph, "the base amount" means the total annual value of increased medical assistance capitation payments, including the voluntary intergovernmental transfers, under this paragraph in calendar year 2017. For managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance capitation payments under this paragraph by an amount equal to ten percent of the base amount, and by an additional ten percent of the base amount for each subsequent contract year until December 31, 2025. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to ~~Hennepin County Medical Center and~~ Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph. This paragraph expires January 1, 2026.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul, and ambulance services owned and operated by another governmental entity that chooses to participate by requesting the commissioner to determine an upper payment limit. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County, the city of St. Paul, and other participating governmental entities of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities. A tribal government that owns and operates an ambulance service is not eligible to participate under this subdivision.

(e) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform the University of Minnesota Medical School and University of

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Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians equal to the difference between the established medical assistance payment for physician, dentist, and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians.

(f) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (e), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

(g) The payments in paragraphs (a) to (e) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

(h) All of the data and funding transactions related to the payments in paragraphs (a) to (e) shall be between the commissioner and the governmental entities.

(i) For purposes of this subdivision, billing professionals are limited to physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and dental therapists.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval of both this section and Minnesota Statutes, section 256B.1973, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 42. **[256B.1973] DIRECTED PAYMENT ARRANGEMENTS.**

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

(b) "Billing professionals" means physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, anesthesiologists, and certified registered anesthetists, and may include dentists, individually enrolled dental hygienists, and dental therapists.

(c) "Health plan" means a managed care or county-based purchasing plan that is under contract with the commissioner to deliver services to medical assistance enrollees under section 256B.69.

(d) "High medical assistance utilization" means a medical assistance utilization rate equal to the standard established in section 256.969, subdivision 9, paragraph (d), clause (6).

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Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians equal to the difference between the established medical assistance payment for physician, dentist, and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians.

(f) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (e), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

(g) The payments in paragraphs (a) to (e) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

(h) All of the data and funding transactions related to the payments in paragraphs (a) to (e) shall be between the commissioner and the governmental entities.

(i) For purposes of this subdivision, billing professionals are limited to physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and dental therapists.

EFFECTIVE DATE. This section is effective December 31, 2021, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 38. **[256B.1973] DIRECTED PAYMENT ARRANGEMENTS.**

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

(b) "Billing professionals" means physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, anesthesiologists, and certified registered anesthetists, and may include dentists, individually enrolled dental hygienists, and dental therapists.

(c) "Health plan" means a managed care or county-based purchasing plan that is under contract with the commissioner to deliver services to medical assistance enrollees under section 256B.69.

(d) "High medical assistance utilization" means a medical assistance utilization rate equal to the standard established in section 256.969, subdivision 9, paragraph (d), clause (6).

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Subd. 2. **Federal approval required.** Each directed payment arrangement under this section is contingent on federal approval and must conform with the requirements for permissible directed managed care organization expenditures under section 256B.6928, subdivision 5.

Subd. 3. **Eligible providers.** Eligible providers under this section are nonstate government teaching hospitals with high medical assistance utilization and a level 1 trauma center and the hospital's affiliated billing professionals, ambulance services, and clinics.

Subd. 4. **Voluntary intergovernmental transfers.** A nonstate governmental entity that is eligible to perform intergovernmental transfers may make voluntary intergovernmental transfers to the commissioner. The commissioner shall inform the nonstate governmental entity of the intergovernmental transfers necessary to maximize the allowable directed payments.

Subd. 5. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall determine a uniform adjustment factor to be applied to each claim submitted by an eligible provider to a health plan. The uniform adjustment factor shall be determined using the average commercial payer rate or using another method acceptable to the Centers for Medicare and Medicaid Services if the average commercial payer rate is not approved, minus the amount necessary for the plan to satisfy tax liabilities under sections 256.9657 and 297I.05 attributable to the directed payment arrangement. The commissioner shall ensure that the application of the uniform adjustment factor maximizes the allowable directed payments and does not result in payments exceeding federal limits, and may use an annual settle-up process. The directed payment shall be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(b) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that the eligible provider receives the entire permissible value of the federally approved directed payment arrangement. If federal approval of a directed payment arrangement under this subdivision is retroactive, the commissioner shall make a onetime pro rata increase to the uniform adjustment factor and the initial payments in order to include claims submitted between the retroactive federal approval date and the period captured by the initial payments.

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Subd. 2. **Federal approval required.** Each directed payment arrangement under this section is contingent on federal approval and must conform with the requirements for permissible directed managed care organization expenditures under section 256B.6928, subdivision 5.

Subd. 3. **Eligible providers.** Eligible providers under this section are nonstate government teaching hospitals with high medical assistance utilization and a level 1 trauma center and the hospital's affiliated billing professionals, ambulance services, and clinics.

Subd. 4. **Voluntary intergovernmental transfers.** A nonstate governmental entity that is eligible to perform intergovernmental transfers may make voluntary intergovernmental transfers to the commissioner. The commissioner shall inform the nonstate governmental entity of the intergovernmental transfers necessary to maximize the allowable directed payments.

Subd. 5. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall determine a uniform adjustment factor to be applied to each claim submitted by an eligible provider to a health plan. The commissioner shall ensure that the application of the uniform adjustment factor maximizes the allowable directed payments and does not result in payments exceeding federal limits, and may use a settle-up process no less than annually to adjust health plan payments to comply with this requirement. The commissioner shall apply the uniform adjustment to each submitted claim.

(b) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner must ensure that the total annual amount of payments equals at least the sum of the annual value of the voluntary intergovernmental transfers to the commissioner under subdivision 4 and federal financial participation.

(c) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that the eligible provider receives the entire permissible value of the federally approved directed payment arrangement. If federal approval of a directed payment arrangement under this subdivision is retroactive, the commissioner shall make a onetime pro rata increase to the uniform adjustment factor and the initial payments in order to include claims submitted between the retroactive federal approval date and the period captured by the initial payments.

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Subd. 6. **Health plan duties; submission of claims.** In accordance with its contract, each health plan shall submit to the commissioner payment information for each claim paid to an eligible provider for services provided to a medical assistance enrollee.

Subd. 7. **Health plan duties; directed payments.** In accordance with its contract, each health plan shall make directed payments to the eligible provider in an amount equal to the payment amounts the plan received from the commissioner.

Subd. 8. **State quality goals.** The directed payment arrangement and state-directed fee schedule requirement must align the state quality goals to Hennepin Healthcare medical assistance patients, including unstably housed individuals, those with higher levels of social and clinical risk, limited English proficiency (LEP) patients, adults with serious chronic conditions, and individuals of color. The directed payment arrangement must maintain quality and access to a full range of health care delivery mechanisms for these patients that may include behavioral health, emergent care, preventive care, hospitalization, transportation, interpreter services, and pharmaceutical services. The commissioner, in consultation with Hennepin Healthcare, shall submit to the Centers for Medicare and Medicaid Services a methodology to measure access to care and the achievement of state quality goals.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later, unless the federal approval provides for an effective date that is before the date the federal approval was issued, including a retroactive effective date, in which case this section is effective retroactively from the federally approved effective date. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 43. Minnesota Statutes 2020, section 256B.69, subdivision 6d, is amended to read:

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

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Subd. 6. **Health plan duties; submission of claims.** In accordance with its contract, each health plan shall submit to the commissioner payment information for each claim paid to an eligible provider for services provided to a medical assistance enrollee.

Subd. 7. **Health plan duties; directed payments.** In accordance with its contract, each health plan shall make directed payments to the eligible provider in an amount equal to the payment amounts the plan received from the commissioner.

Subd. 8. **State quality goals.** The directed payment arrangement and state-directed fee schedule requirement must align the state quality goals to Hennepin Healthcare medical assistance patients, including unstably housed individuals, those with higher levels of social and clinical risk, limited English proficiency patients, adults with serious chronic conditions, or individuals of color. The directed payment arrangement will maintain quality and access to a full range of health care delivery mechanisms for these patients, such as behavioral health, emergent care, preventive care, hospitalization, transportation, interpretation, and pharmaceutical. In partnership with the Department of Human Services, the Centers for Medicare and Medicaid Services, and Hennepin Healthcare, mutually agreed upon measures to demonstrate access to care must be identified and measured.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later, unless the federal approval provides for an effective date after July 1, 2021, but before the date of federal approval, in which case the federally approved effective date applies.

Sec. 39. Minnesota Statutes 2020, section 256B.69, subdivision 6d, is amended to read:

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

(b) Managed care plans and county-based purchasing plans or the plan's subcontractor if the plan subcontracts with a third party to administer pharmacy services, including a pharmacy benefit manager, must comply with section 256B.0625, subdivision 13k, for purposes of contracting with dispensing providers to provide pharmacy services to medical assistance and MinnesotaCare enrollees.

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EFFECTIVE DATE. This section is effective January 1, 2023, or upon completion of the Medicaid Management Information System pharmacy module modernization project, whichever is later. The commissioner shall notify the revisor of statutes when the project is completed.

Sec. 44. Minnesota Statutes 2020, section 256B.69, is amended by adding a subdivision to read:

Subd. 9f. **Annual report on provider reimbursement rates.** (a) The commissioner, by December 15 of each year, shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance a report on managed care and county-based purchasing plan provider reimbursement rates. The report must comply with sections 3.195 and 3.197.

(b) The report must include, for each managed care and county-based purchasing plan, the mean and median provider reimbursement rates by county for the calendar year preceding the reporting year, for the five most common billing codes statewide across all plans, in each of the following provider service categories:

(1) physician services - prenatal and preventive;

(2) physician services - nonprenatal and nonpreventive;

(3) dental services;

(4) inpatient hospital services;

(5) outpatient hospital services; and

(6) mental health services.

(c) The commissioner shall also include in the report:

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Sec. 40. Minnesota Statutes 2020, section 256B.69, is amended by adding a subdivision to read:

Subd. 6f. **Dental fee schedules.** (a) A managed care plan, county-based purchasing plan, or dental benefits administrator as defined under section 256B.0625, subdivision 9c, paragraph (a), must provide individual dental providers, upon request, the applicable fee schedules for covered dental services provided under the contract between the dental provider and the managed care plan, county-based purchasing plan, or dental benefits administrator.

(b) A managed care plan, county-based purchasing plan, or dental benefits administrator may fulfill this requirement by making the applicable fee schedules available through a secure web portal for the contracted dental provider to access.

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(1) the mean and median reimbursement rates across all plans by county for the calendar year preceding the reporting year for the billing codes and provider service categories described in paragraph (b); and

(2) the mean and median fee-for-service reimbursement rates by county for the calendar year preceding the reporting year for the billing codes and provider service categories described in paragraph (b).

Sec. 45. Minnesota Statutes 2020, section 256B.69, is amended by adding a subdivision to read:

Subd. 9g. **Annual report on prepaid health plan reimbursement to 340B covered entities.** (a) By March 1 of each year, each managed care and county-based purchasing plan shall report to the commissioner its reimbursement to 340B covered entities for the previous calendar year. The report must include:

(1) the National Provider Identification (NPI) number for each 340B covered entity;

(2) the name of each 340B covered entity;

(3) the servicing address of each 340B covered entity; and

(4) either: (i) the number of outpatient 340B pharmacy claims and reimbursement amounts; or (ii) the number of professional or facility 340B claim lines and reimbursement amounts.

(b) The commissioner shall submit a copy of the reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by April 1 of each year.

Sec. 46. Minnesota Statutes 2020, section 256B.6928, subdivision 5, is amended to read:

Subd. 5. **Direction of managed care organization expenditures.** (a) The commissioner shall not direct managed care organizations expenditures under the managed care contract, except ~~in~~ as permitted under Code of Federal Regulations, part 42, section 438.6(c). The exception under this paragraph includes the following situations:

(1) implementation of a value-based purchasing model for provider reimbursement, including pay-for-performance arrangements, bundled payments, or other service payments intended to recognize value or outcomes over volume of services;

(2) participation in a multipayer or medical assistance-specific delivery system reform or performance improvement initiative; or

(3) implementation of a minimum or maximum fee schedule, or a uniform dollar or percentage increase for network providers that provide a particular service. The maximum fee schedule must allow the managed care organization the ability to reasonably manage risk and provide discretion in accomplishing the goals of the contract.

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Sec. 41. Minnesota Statutes 2020, section 256B.6928, subdivision 5, is amended to read:

Subd. 5. **Direction of managed care organization expenditures.** (a) The commissioner shall not direct managed care organizations expenditures under the managed care contract, except ~~in~~ as permitted under Code of Federal Regulations, part 42, section 438.6(c). The exception under this paragraph includes the following situations:

(1) implementation of a value-based purchasing model for provider reimbursement, including pay-for-performance arrangements, bundled payments, or other service payments intended to recognize value or outcomes over volume of services;

(2) participation in a multipayer or medical assistance-specific delivery system reform or performance improvement initiative; or

(3) implementation of a minimum or maximum fee schedule, or a uniform dollar or percentage increase for network providers that provide a particular service. The maximum fee schedule must allow the managed care organization the ability to reasonably manage risk and provide discretion in accomplishing the goals of the contract.

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(b) Any managed care contract that directs managed care organization expenditures as permitted under paragraph (a), clauses (1) to (3), must be developed in accordance with Code of Federal Regulations, part 42, sections 438.4 and 438.5; comply with actuarial soundness and generally accepted actuarial principles and practices; and have written approval from the Centers for Medicare and Medicaid Services before implementation. To obtain approval, the commissioner shall demonstrate in writing that the contract arrangement:

(1) is based on the utilization and delivery of services;

(2) directs expenditures equally, using the same terms of performance for a class of providers providing service under the contract;

(3) is intended to advance at least one of the goals and objectives in the commissioner's quality strategy;

(4) has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals in the commissioner's quality strategy;

(5) does not condition network provider participation on the network provider entering into or adhering to an intergovernmental transfer agreement; and

(6) is not renewed automatically.

(c) For contract arrangements identified in paragraph (a), clauses (1) and (2), the commissioner shall:

(1) make participation in the value-based purchasing model, special delivery system reform, or performance improvement initiative available, using the same terms of performance, to a class of providers providing services under the contract related to the model, reform, or initiative; and

(2) use a common set of performance measures across all payers and providers.

(d) The commissioner shall not set the amount or frequency of the expenditures or recoup from the managed care organization any unspent funds allocated for these arrangements.

Sec. 47. Minnesota Statutes 2020, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total

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(b) Any managed care contract that directs managed care organization expenditures as permitted under paragraph (a), clauses (1) to (3), must be developed in accordance with Code of Federal Regulations, part 42, sections 438.4 and 438.5; comply with actuarial soundness and generally accepted actuarial principles and practices; and have written approval from the Centers for Medicare and Medicaid Services before implementation. To obtain approval, the commissioner shall demonstrate in writing that the contract arrangement:

(1) is based on the utilization and delivery of services;

(2) directs expenditures equally, using the same terms of performance for a class of providers providing service under the contract;

(3) is intended to advance at least one of the goals and objectives in the commissioner's quality strategy;

(4) has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals in the commissioner's quality strategy;

(5) does not condition network provider participation on the network provider entering into or adhering to an intergovernmental transfer agreement; and

(6) is not renewed automatically.

(c) For contract arrangements identified in paragraph (a), clauses (1) and (2), the commissioner shall:

(1) make participation in the value-based purchasing model, special delivery system reform, or performance improvement initiative available, using the same terms of performance, to a class of providers providing services under the contract related to the model, reform, or initiative; and

(2) use a common set of performance measures across all payers and providers.

(d) The commissioner shall not set the amount or frequency of the expenditures or recoup from the managed care organization any unspent funds allocated for these arrangements.

Sec. 42. Minnesota Statutes 2020, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total

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aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

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

(2) Effective for services provided on or after January 1, 2023, the rate described in clause (1) shall be increased for hospitals providing high levels of high-cost drugs or 340B drugs. The rate adjustment shall be based on each hospital's share of the total reimbursement for 340B drugs to all critical access hospitals, but shall not exceed three percentage points.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision. When implementing prospective payment methodologies, the commissioner shall use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified in this chapter.

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aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

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

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision. When implementing prospective payment methodologies, the commissioner shall use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified in this chapter.

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

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

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

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

Sec. 48. Minnesota Statutes 2020, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, through December 31, 2022, the commissioner shall make payments for dental services as follows:

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

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

(b) Beginning October 1, 1999, through December 31, 2022, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, through December 31, 2022, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, through December 31, 2022, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

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

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare

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

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

principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

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

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

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

~~(j)~~ (i) Effective for services rendered on or after January 1, 2014, through December 31, 2022, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

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

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

plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

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

(l) Effective for services provided on or after January 1, 2023, payment for dental services shall be the lower of the submitted charge or 86 percent of the fifth percentile of 2018 submitted charges from claims paid by the commissioner. The commissioner shall increase this payment amount by 20 percent for providers designated as critical access dental providers under medical assistance and MinnesotaCare. The critical access dental provider payment add-on shall be calculated to be specific to each individual clinic location within a larger system. This paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

(m) Beginning January 1, 2026, and every four years thereafter, the commissioner shall rebase payment rates for dental services to the first percentile of submitted charges for the applicable base year using charge data from paid claims submitted by providers. The base year used for each rebasing shall be the calendar year that is two years prior to the effective date of the rebasing.

Sec. 49. Minnesota Statutes 2020, section 256B.76, subdivision 4, is amended to read:

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

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

(c) Critical access dental payments made under paragraph (a) or (b) for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments

from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

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

(1) nonprofit community clinics that:

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

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

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

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

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

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

(vii) have free care available as needed;

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

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

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

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

(6) private practicing dentists if:

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

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

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Sec. 50. Minnesota Statutes 2020, section 256B.79, subdivision 1, is amended to read:

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

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

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

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

Sec. 51. Minnesota Statutes 2020, section 256B.79, subdivision 3, is amended to read:

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

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Sec. 43. **[256B.795] MATERNAL AND INFANT HEALTH REPORT.**

(a) The commissioner of human services, in consultation with the commissioner of health, shall submit a biennial report beginning April 15, 2022, to the chairs and ranking minority members of the legislative committees with jurisdiction over health policy and finance on the effectiveness of state maternal and infant health policies and programs addressing health disparities in prenatal and postpartum health outcomes. For each reporting period, the commissioner shall determine the number of women enrolled in the medical assistance program who are pregnant or are in the six months postpartum period of eligibility and the percentage of women in that group who, during each reporting period:

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Sec. 52. Minnesota Statutes 2020, section 256L.01, subdivision 5, is amended to read:

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

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

Sec. 53. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 ~~and~~, to American Indians as defined in Code of Federal Regulations, title 42, section 600.5, or to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

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(1) received prenatal services;

(2) received doula services;

(3) gave birth by primary cesarean section;

(4) gave birth to an infant who received care in the neonatal intensive care unit;

(5) gave birth to an infant who was premature or who had a low birth weight;

(6) experienced excessive blood loss of more than 500 cc of blood;

(7) received postpartum care within six weeks of giving birth; and

(8) received a prenatal and postpartum follow-up home visit from a public health nurse.

(b) These measurements must be determined through an analysis of the utilization data from claims submitted during each reporting period and by any other appropriate means, including the use of utilization data under section 62U.04. The measurements for each metric must be determined in the aggregate and separately for white women, women of color, and indigenous women.

(c) The commissioner shall establish a baseline for the metrics described in paragraph (a) using calendar year 2017. The initial report due April 15, 2022 must contain the baseline metrics and the metrics data for calendar years 2019 and 2021. The following reports due biennially thereafter must contain the metrics for the preceding two calendar years.

Sec. 44. Minnesota Statutes 2020, section 256L.01, subdivision 5, is amended to read:

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

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

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(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

EFFECTIVE DATE. This section is effective January 1, 2022, subject to federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 54. Minnesota Statutes 2020, section 256L.04, subdivision 7b, is amended to read:

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

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

Sec. 55. Minnesota Statutes 2020, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Redetermination of eligibility.** (a) An enrollee's eligibility must be redetermined on an annual basis~~, in accordance with Code of Federal Regulations, title 42, section 435.916 (a). The 12-month eligibility period begins the month of application. Beginning July 1, 2017, the commissioner shall adjust the eligibility period for enrollees to implement renewals throughout the year according to guidance from the Centers for Medicare and Medicaid Services~~. The period of eligibility is the entire calendar year following the year in which eligibility is redetermined. Eligibility redeterminations shall occur during the open enrollment period for qualified health plans as specified in Code of Federal Regulations, title 45, section 155.410(e)(3).

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

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

Sec. 56. Minnesota Statutes 2020, section 256L.07, subdivision 2, is amended to read:

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

(b) Notwithstanding paragraph (a), an individual who has access through a spouse's or parent's employer to subsidized health coverage that is deemed minimum essential coverage under Code of Federal Regulations, title 26, section 1.36B-2, is eligible for MinnesotaCare if the employee's portion of the annual premium for employee and dependent coverage exceeds the required contribution percentage, as defined for premium tax credit eligibility under United States Code, title 26, section 36B(c)(2)(C)(i)(II), as indexed according to item (iv) of that section, of the individual's household income for the coverage year.

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Sec. 45. Minnesota Statutes 2020, section 256L.04, subdivision 7b, is amended to read:

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

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

Sec. 46. Minnesota Statutes 2020, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Redetermination of eligibility.** (a) An enrollee's eligibility must be redetermined on an annual basis~~, in accordance with Code of Federal Regulations, title 42, section 435.916 (a). The 12-month eligibility period begins the month of application. Beginning July 1, 2017, the commissioner shall adjust the eligibility period for enrollees to implement renewals throughout the year according to guidance from the Centers for Medicare and Medicaid Services~~. The period of eligibility is the entire calendar year following the year in which eligibility is redetermined. Eligibility redeterminations shall occur during the open enrollment period for qualified health plans as specified in Code of Federal Regulations, title 45, section 155.410(e)(3).

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

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

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

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

Sec. 57. Minnesota Statutes 2020, section 256L.11, subdivision 6a, is amended to read:

Subd. 6a. **Dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2018, through December 31, 2022, the commissioner shall increase payment rates to dental providers by 54 percent. Payments made to prepaid health plans under section 256L.12 shall reflect the payment increase described in this subdivision. The prepaid health plans under contract with the commissioner shall provide payments to dental providers that are at least equal to a rate that includes the payment rate specified in this subdivision, and if applicable to the provider, the rates described under subdivision 7.

Sec. 58. Minnesota Statutes 2020, section 256L.11, subdivision 7, is amended to read:

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

Sec. 59. Minnesota Statutes 2020, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).

(c) Paragraph (b) does not apply to:

(1) children 20 years of age or younger; and

(2) individuals with household incomes below 35 percent of the federal poverty guidelines.

(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

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Sec. 47. Minnesota Statutes 2020, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).

(c) Paragraph (b) does not apply to:

(1) children 20 years of age or younger; and

(2) individuals with household incomes below 35 percent of the federal poverty guidelines.

(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

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Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
35%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$14
120%	130%	$15
130%	140%	$16
140%	150%	$25
150%	160%	$37
160%	170%	$44
170%	180%	$52
180%	190%	$61
190%	200%	$71
200%		$80

(e) Retroactive to January 1, 2021, the commissioner shall adjust the premium schedule under paragraph (d) to ensure that MinnesotaCare premiums do not exceed the amount that an individual would have been required to pay if the individual was enrolled in an applicable benchmark plan in accordance with Code of Federal Regulations, title 42, section 600.505(a)(1).

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

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Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
35%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$14
120%	130%	$15
130%	140%	$16
140%	150%	$25
150%	160%	$37
160%	170%	$44
170%	180%	$52
180%	190%	$61
190%	200%	$71
200%		$80

(e) Beginning January 1, 2021, the commissioner shall adjust the premium scale established under paragraph (d) to ensure that premiums do not exceed the amount that an individual would have been required to pay if the individual was enrolled in an applicable benchmark plan in accordance with the Code of Federal Regulations, title 42, section 600.505(a)(1).

EFFECTIVE DATE. This section is effective retroactively from January 1, 2021 and applies to premiums due on or after that date.

Sec. 48. Minnesota Statutes 2020, section 256L.15, is amended by adding a subdivision to read:

Subd. 5. **Tobacco use premium surcharge.** (a) An enrollee who uses tobacco products as defined in paragraph (e) and is not actively participating in a tobacco cessation program must pay a tobacco premium surcharge in an amount that is equal to ten percent of the

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Sec. 60. Minnesota Statutes 2020, section 295.53, subdivision 1, is amended to read:

Subdivision 1. **Exclusions and exemptions.** (a) The following payments are excluded from the gross revenues subject to the hospital, surgical center, or health care provider taxes under sections 295.50 to 295.59:

(1) payments received by a health care provider or the wholly owned subsidiary of a health care provider for care provided outside Minnesota;

(2) government payments received by the commissioner of human services for state-operated services;

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enrollee's monthly premium. The tobacco use premium surcharge must be calculated on a monthly basis and paid in accordance with section 256L.06, rounded up to the nearest dollar amount. Nonpayment of the surcharge may result in disenrollment.

(b) Enrollees who initially apply or renew enrollment in the MinnesotaCare program on or after July 1, 2021, must attest as part of the application or renewal process whether the enrollee is using tobacco products and if so, whether the enrollee is actively participating in a tobacco cessation program. Upon request of the commissioner, the enrollee must provide documentation verifying that the enrollee is actively participating in tobacco cessation.

(c) If an enrollee indicates on the initial application or at renewal that the enrollee does not use tobacco or is using tobacco products but is actively participating in a tobacco cessation program, and it is determined that the enrollee was using tobacco products and was not actively participating in a tobacco cessation program during the period of enrollment, the enrollee must pay the total amount of the tobacco use premium surcharge that the enrollee would have been required to pay as a tobacco user during that enrollment period. If the enrollee fails to pay the surcharge amount due, the enrollee may be disenrolled and the unpaid amount may be subject to recovery by the commissioner.

(d) Nonpayment of the surcharge amount owed by the enrollee under paragraph (a) or (c) shall result in disenrollment effective for the calendar month following the month for which the surcharge was due. Disenrollment for nonpayment of the surcharge must meet the requirements in section 256L.06, subdivision 3, paragraphs (d) and (e).

(e) For purposes of this subdivision, the use of tobacco products means the use of a tobacco product four or more times per week within the past six months. Tobacco products include the use of cigarettes, cigars, pipe tobacco, chewing tobacco, or snuff. Tobacco products do not include the use of tobacco by an American Indian who meets the requirements in Code of Federal Regulations, title 42, sections 447.51 and 447.56, as part of a traditional Native American spiritual or cultural ceremony.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 49. Minnesota Statutes 2020, section 295.53, subdivision 1, is amended to read:

Subdivision 1. **Exclusions and exemptions.** (a) The following payments are excluded from the gross revenues subject to the hospital, surgical center, or health care provider taxes under sections 295.50 to 295.59:

(1) payments received by a health care provider or the wholly owned subsidiary of a health care provider for care provided outside Minnesota;

(2) government payments received by the commissioner of human services for state-operated services;

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(3) payments received by a health care provider for hearing aids and related equipment or prescription eyewear delivered outside of Minnesota; and

(4) payments received by an educational institution from student tuition, student activity fees, health care service fees, government appropriations, donations, or grants, and for services identified in and provided under an individualized education program as defined in section 256B.0625 or Code of Federal Regulations, chapter 34, section 300.340(a). Fee for service payments and payments for extended coverage are taxable.

(b) The following payments are exempted from the gross revenues subject to hospital, surgical center, or health care provider taxes under sections 295.50 to 295.59:

(1) payments received for services provided under the Medicare program, including payments received from the government and organizations governed by sections 1833, 1853, and 1876 of title XVIII of the federal Social Security Act, United States Code, title 42, section 1395; and enrollee deductibles, co-insurance, and co-payments, whether paid by the Medicare enrollee, by Medicare supplemental coverage as described in section 62A.011, subdivision 3, clause (10), or by Medicaid payments under title XIX of the federal Social Security Act. Payments for services not covered by Medicare are taxable;

(2) payments received for home health care services;

(3) payments received from hospitals or surgical centers for goods and services on which liability for tax is imposed under section 295.52 or the source of funds for the payment is exempt under clause (1), (6), (9), (10), or (11);

(4) payments received from the health care providers for goods and services on which liability for tax is imposed under this chapter or the source of funds for the payment is exempt under clause (1), (6), (9), (10), or (11);

(5) amounts paid for legend drugs to a wholesale drug distributor who is subject to tax under section 295.52, subdivision 3, reduced by reimbursement received for legend drugs otherwise exempt under this chapter;

(6) payments received from the chemical dependency fund under chapter 254B;

(7) payments received in the nature of charitable donations that are not designated for providing patient services to a specific individual or group;

(8) payments received for providing patient services incurred through a formal program of health care research conducted in conformity with federal regulations governing research on human subjects. Payments received from patients or from other persons paying on behalf of the patients are subject to tax;

(9) payments received from any governmental agency for services benefiting the public, not including payments made by the government in its capacity as an employer or insurer or payments made by the government for services provided under the MinnesotaCare

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(3) payments received by a health care provider for hearing aids and related equipment or prescription eyewear delivered outside of Minnesota; and

(4) payments received by an educational institution from student tuition, student activity fees, health care service fees, government appropriations, donations, or grants, and for services identified in and provided under an individualized education program as defined in section 256B.0625 or Code of Federal Regulations, chapter 34, section 300.340(a). Fee for service payments and payments for extended coverage are taxable.

(b) The following payments are exempted from the gross revenues subject to hospital, surgical center, or health care provider taxes under sections 295.50 to 295.59:

(1) payments received for services provided under the Medicare program, including payments received from the government and organizations governed by sections 1833, 1853, and 1876 of title XVIII of the federal Social Security Act, United States Code, title 42, section 1395; and enrollee deductibles, co-insurance, and co-payments, whether paid by the Medicare enrollee, by Medicare supplemental coverage as described in section 62A.011, subdivision 3, clause (10), or by Medicaid payments under title XIX of the federal Social Security Act. Payments for services not covered by Medicare are taxable;

(2) payments received for home health care services;

(3) payments received from hospitals or surgical centers for goods and services on which liability for tax is imposed under section 295.52 or the source of funds for the payment is exempt under clause (1), (6), (9), (10), or (11);

(4) payments received from the health care providers for goods and services on which liability for tax is imposed under this chapter or the source of funds for the payment is exempt under clause (1), (6), (9), (10), or (11);

(5) amounts paid for legend drugs to a wholesale drug distributor who is subject to tax under section 295.52, subdivision 3, reduced by reimbursement received for legend drugs otherwise exempt under this chapter;

(6) payments received from the chemical dependency fund under chapter 254B;

(7) payments received in the nature of charitable donations that are not designated for providing patient services to a specific individual or group;

(8) payments received for providing patient services incurred through a formal program of health care research conducted in conformity with federal regulations governing research on human subjects. Payments received from patients or from other persons paying on behalf of the patients are subject to tax;

(9) payments received from any governmental agency for services benefiting the public, not including payments made by the government in its capacity as an employer or insurer or payments made by the government for services provided under the MinnesotaCare

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program or the medical assistance program governed by title XIX of the federal Social Security Act, United States Code, title 42, sections 1396 to 1396v;

(10) payments received under the federal Employees Health Benefits Act, United States Code, title 5, section 8909(f), as amended by the Omnibus Reconciliation Act of 1990. Enrollee deductibles, co-insurance, and co-payments are subject to tax;

(11) payments received under the federal Tricare program, Code of Federal Regulations, title 32, section 199.17(a)(7). Enrollee deductibles, co-insurance, and co-payments are subject to tax; and

(12) supplemental ~~or~~, enhanced, or uniform adjustment factor payments authorized under section 256B.196 ~~or~~, 256B.197, or 256B.1973.

(c) Payments received by wholesale drug distributors for legend drugs sold directly to veterinarians or veterinary bulk purchasing organizations are excluded from the gross revenues subject to the wholesale drug distributor tax under sections 295.50 to 295.59.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2021.

Sec. 61. **COURT RULING ON AFFORDABLE CARE ACT.**

In the event the United States Supreme Court reverses, in whole or in part, Public Law 111-148, as amended by Public Law 111-152, the commissioner of human services shall take all actions necessary to maintain the current policies of the medical assistance and MinnesotaCare programs, including but not limited to pursuing federal funds, or if federal funding is not available, operating programs with state funding for at least one year following the date of the Supreme Court decision or until the conclusion of the next regular legislative session, whichever is later. Nothing in this section prohibits the commissioner from making changes necessary to comply with federal or state requirements for the medical assistance or MinnesotaCare programs that were not affected by the Supreme Court decision.

Sec. 62. **DELIVERY REFORM ANALYSIS REPORT.**

(a) The commissioner of human services shall present to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance, by January 15, 2023, a report comparing service delivery and payment system models for delivering services to Medical Assistance enrollees for whom income eligibility is determined using the modified adjusted gross income methodology under Minnesota Statutes, section 256B.056, subdivision 1a, paragraph (b), clause (1), and MinnesotaCare enrollees eligible under Minnesota Statutes, chapter 256L. The report must compare the current delivery model with at least two alternative models. The alternative models must include a state-based model in which the state holds the plan risk as the insurer and may contract with a third-party administrator for claims processing and plan administration. The alternative models may include but are not limited to:

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program or the medical assistance program governed by title XIX of the federal Social Security Act, United States Code, title 42, sections 1396 to 1396v;

(10) payments received under the federal Employees Health Benefits Act, United States Code, title 5, section 8909(f), as amended by the Omnibus Reconciliation Act of 1990. Enrollee deductibles, co-insurance, and co-payments are subject to tax;

(11) payments received under the federal Tricare program, Code of Federal Regulations, title 32, section 199.17(a)(7). Enrollee deductibles, co-insurance, and co-payments are subject to tax; and

(12) supplemental ~~or~~, enhanced, or directed payments authorized under section 256B.196 ~~or~~, 256B.197, or 256B.1973.

(c) Payments received by wholesale drug distributors for legend drugs sold directly to veterinarians or veterinary bulk purchasing organizations are excluded from the gross revenues subject to the wholesale drug distributor tax under sections 295.50 to 295.59.

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

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(1) expanding the use of integrated health partnerships under Minnesota Statutes, section 256B.0755;

(2) delivering care under fee-for-service through a primary care case management system; and

(3) continuing to contract with managed care and county-based purchasing plans for some or all enrollees under modified contracts.

(b) The report must include:

(1) a description of how each model would address:

(i) racial and other inequities in the delivery of health care and health care outcomes;

(ii) geographic inequities in the delivery of health care;

(iii) the provision of incentives for preventive care and other best practices;

(iv) reimbursing providers for high-quality, value-based care at levels sufficient to sustain or increase enrollee access to care; and

(v) transparency and simplicity for enrollees, health care providers, and policymakers;

(2) a comparison of the projected cost of each model; and

(3) an implementation timeline for each model, that includes the earliest date by which each model could be implemented if authorized during the 2023 legislative session, and a discussion of barriers to implementation.

Sec. 63. **DENTAL HOME DEMONSTRATION PROJECT.**

(a) The Dental Services Advisory Committee, in collaboration with stakeholders, shall design a dental home demonstration project and present recommendations by February 1, 2022, to the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over health finance and policy.

(b) The Dental Services Advisory Committee, at a minimum, shall engage with the following stakeholders: the Minnesota Department of Health, the Minnesota Dental Association, the Minnesota Dental Hygienists' Association, the University of Minnesota School of Dentistry, dental programs operated by the Minnesota State Colleges and Universities system, and representatives of each of the following dental provider types serving medical assistance and MinnesotaCare enrollees:

(1) private practice dental clinics for which medical assistance and MinnesotaCare enrollees comprise more than 25 percent of the clinic's patient load;

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Sec. 51. **DENTAL HOME DEMONSTRATION PROJECT PLAN.**

(a) The commissioner of human services shall develop a plan to implement a dental home demonstration project. The demonstration project must create dental homes to provide incentives to dental providers for the provision of patient-centered, high quality, comprehensive, and coordinated dental care to medical assistance and MinnesotaCare enrollees. The demonstration project must be designed to establish and evaluate alternative models of delivery systems and payment methods that:

(1) emphasize, enhance, and encourage access to primary dental care by using dental teams that include dentists, dental hygienists, dental therapists, advanced dental therapists, and dental assistants;

(2) ensure enrollees with a consistent and ongoing contact with a dental provider or dental team and coordination with the enrollee's medical care;

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(2) private practice dental clinics for which medical assistance and MinnesotaCare enrollees comprise 25 percent or less of the clinic's patient load;

(3) nonprofit dental clinics with a primary focus on serving Indigenous communities and other communities of color;

(4) nonprofit dental clinics with a primary focus on providing eldercare;

(5) nonprofit dental clinics with a primary focus on serving children;

(6) nonprofit dental clinics providing services within the seven-county metropolitan area;

(7) nonprofit dental clinics providing services outside of the seven-county metropolitan area; and

(8) multispecialty hospital-based dental clinics.

(c) The dental home demonstration project shall give incentives for qualified providers that provide high-quality, patient-centered, comprehensive, and coordinated oral health services. The demonstration project shall seek to increase the number of new dental providers serving medical assistance and MinnesotaCare enrollees and increase the capacity of existing providers. The demonstration project must test payment methods that establish value-based incentives to:

(1) increase the extent to which current dental providers serve medical assistance and MinnesotaCare enrollees across their lifespan;

(2) develop service models that create equity and reduce disparities in access to dental services for high-risk and medically and socially complex enrollees;

(3) advance alternative delivery models of care within community settings using evidence-based approaches and innovative workforce teams; and

(4) improve the quality of dental care by meeting dental home goals.

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(3) decrease administrative burdens and create greater transparency and accountability;

(4) incorporate outcome measures on access, quality, cost of care and patient experience; and

(5) establish value-based incentives to:

(i) provide flexibility in enrollment criteria in order to increase the number of dental providers currently serving medical assistance and MinnesotaCare enrollees;

(ii) reduce disparities in access to dental services for high risk and medically and socially complex patients; and

(iii) increase overall access to quality dental services.

(b) The commissioner shall develop outcome measures for the demonstration projects that include measurements for access to preventive care, follow-up care after an oral health evaluation, patient satisfaction, and administrative costs for delivering dental services.

(c) In developing the dental home demonstration project, the commissioner shall consult with interested stakeholders including but not limited to representatives of:

(1) private practice dental clinics for which medical assistance and MinnesotaCare enrollees comprise more than 25 percent of the clinic's patient load;

(2) nonprofit dental clinics with a primary focus on serving Indigenous communities and other communities of color;

(3) nonprofit dental clinics with a primary focus on providing eldercare;

(4) nonprofit dental clinics with a primary focus on serving children;

(5) nonprofit dental clinics providing services in the seven-county metropolitan area;

(6) nonprofit dental clinics providing services outside of the seven-county metropolitan area;

(7) multispecialty hospital-based dental clinics; and

(8) educational institutions operating dental programs.

(d) The commissioner of human services shall submit recommendations for the establishment of a dental home demonstration project to the chairs and ranking minority

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Sec. 64. **DIRECTION TO COMMISSIONER; INCOME AND ASSET EXCLUSION FOR ST. PAUL GUARANTEED INCOME DEMONSTRATION PROJECT.**

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

(b) "Commissioner" means the commissioner of human services unless specified otherwise.

(c) "Guaranteed income demonstration project" means a demonstration project in St. Paul to evaluate how unconditional cash payments have a causal effect on income volatility, financial well-being, and early childhood development in infants and toddlers.

Subd. 2. **Commissioner; income and asset exclusion.** (a) During the duration of the guaranteed income demonstration project, the commissioner shall not count payments made to families by the guaranteed income demonstration project as income or assets for purposes of determining or redetermining eligibility for the following programs:

(1) child care assistance programs under Minnesota Statutes, chapter 119B; and

(2) the Minnesota family investment program, work benefit program, or diversionary work program under Minnesota Statutes, chapter 256J.

(b) During the duration of the guaranteed income demonstration project, the commissioner shall not count payments made to families by the guaranteed income demonstration project as income or assets for purposes of determining or redetermining eligibility for the following programs:

(1) medical assistance under Minnesota Statutes, chapter 256B; and

(2) MinnesotaCare under Minnesota Statutes, chapter 256L.

Subd. 3. **Report.** The city of St. Paul shall provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance by February 15, 2023, with information on the progress and outcomes of the guaranteed income demonstration project under this section.

Subd. 4. **Expiration.** This section expires June 30, 2023.

EFFECTIVE DATE. This section is effective July 1, 2021, except for subdivision 2, paragraph (b), which is effective July 1, 2021, or upon federal approval, whichever is later.

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members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2022.

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

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Sec. 65. **EXPANSION OF OUTPATIENT DRUG CARVE OUT; PRESCRIPTION DRUG PURCHASING PROGRAM.**

The commissioner of human services, in consultation with the commissioners of commerce and health, shall assess the feasibility of, and develop recommendations for: (1) expanding the outpatient prescription drug carve out under Minnesota Statutes, section 256B.69, subdivision 6d, to include MinnesotaCare enrollees; and (2) establishing a prescription drug purchasing program to serve nonpublic program enrollees of health plan companies. The recommendations must address the process and terms by which the commissioner would contract with health plan companies to administer prescription drug benefits for the companies' enrollees and develop and manage a formulary. The commissioner shall present recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services policy and finance by December 15, 2023.

Sec. 66. **FEDERAL APPROVAL; EXTENSION OF POSTPARTUM COVERAGE.**

The commissioner of human services shall seek all federal waivers and approvals necessary to extend medical assistance postpartum coverage, as provided in Minnesota Statutes, section 256B.055, subdivision 6.

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

Sec. 67. **PROPOSAL FOR A PUBLIC OPTION.**

(a) The commissioner of human services shall consult with the Centers for Medicare and Medicaid Services, the Internal Revenue Service, and other relevant federal agencies to develop a proposal for a public option program. The proposal may consider multiple public option structures, at least one of which must be through expanded enrollment into MinnesotaCare. Each option must:

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Sec. 50. **CAPITATION PAYMENT DELAY.**

(a) The commissioner of human services shall delay $93,742,000 of the medical assistance capitation payment to managed care plans and county-based purchasing plans due in May 2023 until July 1, 2023. The payment shall be made no earlier than July 1, 2023, and no later than July 31, 2023.

(b) The commissioner of human services shall delay $114,103,000 of the medical assistance capitation payment to managed care plans and county-based purchasing plans due in May 2025 until July 1, 2025. The payment shall be made no earlier than July 1, 2025, and no later than July 31, 2025

Sec. 52. **FEDERAL APPROVAL; EXTENSION OF POSTPARTUM COVERAGE.**

The commissioner of human services shall seek all necessary federal waivers and approvals necessary to extend medical assistance postpartum coverage, as provided in Minnesota Statutes, section 256B.055, subdivision 6.

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

(1) allow individuals with incomes above the maximum income eligibility limit under Minnesota Statutes, section 256L.04, subdivision 1 or 7, the option of purchasing coverage through the public option;

(2) allow undocumented noncitizens, and individuals with access to subsidized employer health coverage who are subject to the family glitch, the option of purchasing through the public option;

(3) establish a small employer public option that allows employers with 50 or fewer employees to offer the public option to the employer's employees and contribute to the employees' premiums;

(4) allow the state to:

(i) receive the maximum pass through of federal dollars that would otherwise be used to provide coverage for eligible public option enrollees if the enrollees were instead covered through qualified health plans with premium tax credits, emergency medical assistance, or other relevant programs; and

(ii) continue to receive basic health program payments for eligible MinnesotaCare enrollees; and

(5) be administered in coordination with the existing MinnesotaCare program to maximize efficiency and improve continuity of care, consistent with the requirements of Minnesota Statutes, sections 256L.06, 256L.10, and 256L.11.

(b) Each public option proposal must include:

(1) a premium scale for public option enrollees that at least meets the Affordable Care Act affordability standard for each income level;

(2) an analysis of the impact of the public option on MNsure enrollment and the consumer assistance program and, if necessary, a proposal to ensure that the public option has an adequate enrollment infrastructure and consumer assistance capacity;

(3) actuarial and financial analyses necessary to project program enrollment and costs; and

(4) an analysis of the cost of implementing the public option using current eligibility and enrollment technology systems, and at the option of the commissioner, an analysis of alternative eligibility and enrollment systems that may reduce initial and ongoing costs and improve functionality and accessibility.

(c) The commissioner shall incorporate into the design of the public option mechanisms to ensure the long-term financial sustainability of MinnesotaCare and mitigate any adverse financial impacts to MNsure. These mechanisms must minimize: (i) adverse selection; (ii)

state financial risk and expenditures; and (iii) potential impacts on premiums in the individual and group insurance markets.

(d) The commissioner shall present the proposal to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by December 15, 2021. The proposal must include recommendations on any legislative changes necessary to implement the public option. Any implementation of the proposal that requires a state financial contribution must be contingent on legislative approval.

Sec. 68. **RESPONSE TO COVID-19 PUBLIC HEALTH EMERGENCY.**

(a) Notwithstanding Minnesota Statutes, section 256B.057, subdivision 9, 256L.06, subdivision 3, or any other provision to the contrary, the commissioner shall not collect any unpaid premium for a coverage month that occurred during the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

(b) Notwithstanding any provision to the contrary, periodic data matching under Minnesota Statutes, section 256B.0561, subdivision 2, may be suspended for up to six months following the last day of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

(c) Notwithstanding any provision to the contrary, the requirement for the commissioner of human services to issue an annual report on periodic data matching under Minnesota Statutes, section 256B.0561, is suspended for one year following the last day of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

EFFECTIVE DATE. This section is effective the day following final enactment, except paragraph (a) related to MinnesotaCare premiums is effective upon federal approval. The commissioner shall notify the revisor of statutes when federal approval is received.

Sec. 53. **OVERPAYMENTS FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, OR SUPPLIES.**

(a) Notwithstanding any other law to the contrary, providers who received payment for durable medical equipment, prosthetics, orthotics, or supplies between January 1, 2018, and June 30, 2019, that were subject to the upper payment limits under United States Code, title 42, section 1396b(i)(27), shall not be required to repay any amount received in excess of the allowable amount to either the state or the Centers for Medicare and Medicaid Services.

(b) The state shall repay with state funds any amount owed to the Centers for Medicare and Medicaid Services for the federal financial participation amount received by the state for payments identified in paragraph (a) in excess of the amount allowed effective January 1, 2018, and the state shall hold harmless the providers who received these payments from

recovery of both the state and federal share of the amount determined to have exceeded the Medicare upper payment limit.

(c) Nothing in this section shall be construed to prohibit the commissioner from recouping past overpayments due to false claims or for reasons other than exceeding the Medicare upper payment limits or from recouping future overpayments including the recoupment of payments that exceed the upper Medicare payment limits.

Sec. 54. **PROPOSED FORMULARY COMMITTEE.**

By March 1, 2022, the commissioner of human services, in consultation with relevant professional associations and consumer groups, shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a proposed reorganization of the Formulary Committee under Minnesota Statutes, section 256B.0625, subdivision 13c, that includes:

(1) the proposed membership of the committee, including adequate representation of consumers and health care professionals with expertise in clinical prescribing; and

(2) proposed policies and procedures for the operation of the committee that ensures public input, including providing public notice and gathering public comments on the committee's recommendations and proposed actions.

Sec. 56. **DIRECTION TO COMMISSIONER; DIRECTED PAYMENT APPLICATION.**

The commissioner of human services, in consultation with Hennepin Healthcare System, shall submit Section 438.6(c) Preprint to the Centers for Medicare and Medicaid Services no later than July 31, 2021. The commissioner shall request from the Centers for Medicare and Medicaid Services an effective date of January 1, 2022.

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

Sec. 58. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; FUNDING FOR RECUPERATIVE CARE.**

The commissioner of human services shall develop a medical assistance reimbursable recuperative care service, not limited to a health home model, designed to serve individuals with chronic conditions, as defined in United States Code, title 42, section 1396w-4(h), who also lack a permanent place of residence at the time of discharge from an emergency department or hospital in order to prevent a return to the emergency department, readmittance to the hospital, or hospitalization. This section is contingent on the receipt of nonstate funding to the commissioner of human services for this purpose as permitted by Minnesota Statutes, section 256.01, subdivision 25.

House Language H2128-4

Sec. 69. **REVISOR INSTRUCTION.**

The revisor of statutes must change the term "Health Services Policy Committee" to "Health Services Advisory Council" wherever the term appears in Minnesota Statutes and may make any necessary changes to grammar or sentence structure to preserve the meaning of the text.

Sec. 70. **REPEALER.**

(a) Minnesota Rules, parts 9505.0275; 9505.1693; 9505.1696, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, and 22; 9505.1699; 9505.1701; 9505.1703; 9505.1706; 9505.1712; 9505.1715; 9505.1718; 9505.1724; 9505.1727; 9505.1730; 9505.1733; 9505.1736; 9505.1739; 9505.1742; 9505.1745; and 9505.1748, are repealed.

(b) Minnesota Statutes 2020, section 256B.0625, subdivisions 18c, 18d, 18e, and 18h, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective July 1, 2021, and paragraph (b) is effective January 1, 2023.

Senate Language UEH2128-1

Sec. 60. **REVISOR INSTRUCTION.**

The revisor of statutes must change the term "Health Services Policy Committee" to "Health Services Advisory Council" wherever the term appears in Minnesota Statutes and may make any necessary changes to grammar or sentence structure to preserve the meaning of the text.

Sec. 61. **REPEALER.**

Minnesota Statutes 2020, section 16A.724, subdivision 2, is repealed effective July 1, 2024.