ARTICLE 4
HEALTH CARE POLICY

Section 1. Minnesota Statutes 2020, section 62J.2930, subdivision 3, is amended to read:

Subd. 3. Consumer information. (a) The information clearinghouse or another entity designated by the commissioner shall provide consumer information to health plan company enrollees to:

(1) assist enrollees in understanding their rights;
(2) explain and assist in the use of all available complaint systems, including internal complaint systems within health carriers, community integrated service networks, and the Departments of Health and Commerce;
(3) provide information on coverage options in each region of the state;
(4) provide information on the availability of purchasing pools and enrollee subsidies; and
(5) help consumers use the health care system to obtain coverage.

(b) The information clearinghouse or other entity designated by the commissioner for the purposes of this subdivision shall not:

(1) provide legal services to consumers;
(2) represent a consumer or enrollee; or
(3) serve as an advocate for consumers in disputes with health plan companies.

(c) Nothing in this subdivision shall interfere with the ombudsman program established under section 256B.69, subdivision 20 or 256B.6903, or other existing ombudsman programs.

Sec. 2. Minnesota Statutes 2020, section 256B.055, subdivision 2, is amended to read:

Subd. 2. Subsidized foster children. Medical assistance may be paid for a child eligible for or receiving foster care maintenance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, and for a child who is determined eligible for kinship assistance under chapter 256N.

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

Sec. 3. Minnesota Statutes 2020, section 256B.056, subdivision 3b, is amended to read:

Subd. 3b. Treatment of trusts. (a) It is the public policy of this state that individuals use all available resources to pay for the cost of long-term care services, as defined in section 255B.0595, before turning to Minnesota health care program funds, and that trust instruments...
should not be permitted to shield available resources of an individual or an individual's spouse from such use.

(a) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with a developmental disability living in an intermediate care facility for persons with developmental disabilities; or (3) a trust set up by a person with payments made by the Social Security Administration pursuant to the United States Supreme Court decision in Sullivan v. Zebley, 110 S. Ct. 885 (1990). The maximum amount of payments that a trustee of a medical assistance qualifying trust may make to a person under the terms of the trust is considered to be available assets to the person, without regard to whether the trustee actually makes the maximum payments to the person and without regard to the purpose for which the medical assistance qualifying trust was established.

(b) Trusts established after August 10, 1993, are treated according to United States Code, title 42, section 1396p(d).

(c) For purposes of paragraph (d), a pooled trust means a trust established under United States Code, title 42, section 1396p(d)(4)(C).

(d) A beneficiary's interest in a pooled trust is considered an available asset unless the trust provides that upon the death of the beneficiary or termination of the trust during the beneficiary's lifetime, whichever is sooner, the department receives any amount, up to the amount of medical assistance benefits paid on behalf of the beneficiary, remaining in the beneficiary's trust account after a deduction for reasonable administrative fees and expenses, and an additional remainder amount. The retained remainder amount of the subaccount must not exceed ten percent of the account value at the time of the beneficiary's death or termination of the trust, and must only be used for the benefit of disabled individuals who have a beneficiary interest in the pooled trust.

(e) Trusts may be established on or after December 12, 2016, by a person who has been determined to be disabled, according to United States Code, title 42, section 1396p(d)(4)(A), as amended by section 5007 of the 21st Century Cures Act, Public Law 114-255.

EFFECTIVE DATE. This section is effective the day following final enactment.
reduced to the maximum at the time of an eligibility redetermination. The value of assets
that are not considered in determining eligibility for medical assistance for families and
children is the value of those assets excluded under the AFDC state plan as of July 16, 1996,
as required by the Personal Responsibility and Work Opportunity Reconciliation Act of
1996 (PRWORA), Public Law 104-193, with the following exceptions:

(1) household goods and personal effects are not considered;
(2) capital and operating assets of a trade or business up to $200,000 are not considered;
(3) one motor vehicle is excluded for each person of legal driving age who is employed
or seeking employment;

(4) assets designated as burial expenses are excluded to the same extent they are excluded
by the Supplemental Security Income program;
(5) court-ordered settlements up to $10,000 are not considered;
(6) individual retirement accounts and funds are not considered;
(7) assets owned by children are not considered; and

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

(b) Beginning January 1, 2014, this subdivision Paragraph (a) applies only to parents
and caretaker relatives who qualify for medical assistance under subdivision 5.
(c) Eligibility for children under age 21 must be determined without regard to the asset
limitations described in paragraphs (a) and (b) and subdivision 3.

Sec. 5. Minnesota Statutes 2020, section 256B.056, subdivision 11, is amended to read:

Subd. 11. Treatment of annuities. (a) Any person requesting medical assistance payment
of long-term care services shall provide a complete description of any interest either the
person or the person's spouse has in annuities on a form designated by the department. The
form shall include a statement that the state becomes a preferred remainder beneficiary of
annuities or similar financial instruments by virtue of the receipt of medical assistance
payment of long-term care services. The person and the person's spouse shall furnish the
agency responsible for determining eligibility with complete current copies of their annuities
and related documents and complete the form designating the state as the preferred remainder
beneficiary for each annuity in which the person or the person's spouse has an interest.

(b) The department shall provide notice to the issuer of the department's right under this
section as a preferred remainder beneficiary under the annuity or similar financial instrument
for medical assistance furnished to the person or the person's spouse, and provide notice of
the issuer's responsibilities as provided in paragraph (c).
(c) An issuer of an annuity or similar financial instrument who receives notice of the
state's right to be named a preferred remainder beneficiary as described in paragraph (b)
shall provide confirmation to the requesting agency that the state has been made a preferred
remainder beneficiary. The issuer shall also notify the county agency when a change in the
amount of income or principal being withdrawn from the annuity or other similar financial
instrument or a change in the state's preferred remainder beneficiary designation under the
annuity or other similar financial instrument occurs. The county agency shall provide the
issuer with the name, address, and telephone number of a unit within the department that
the issuer can contact to comply with this paragraph.

(d) "Preferred remainder beneficiary" for purposes of this subdivision and sections
256B.0594 and 256B.0595 means the state is a remainder beneficiary in the first position
in an amount equal to the amount of medical assistance paid on behalf of the institutionalized
person, or is a remainder beneficiary in the second position if the institutionalized person
designates and is survived by a remainder beneficiary who is (1) a spouse who does not
reside in a medical institution, (2) a minor child, or (3) a child of any age who is blind or
permanently and totally disabled as defined in the Supplemental Security Income program.

Notwithstanding this paragraph, the state is the remainder beneficiary in the first position
if the spouse or child disposes of the remainder for less than fair market value.

(e) For purposes of this subdivision, "institutionalized person" and "long-term care
services" have the meanings given in section 256B.0595, subdivision 1, paragraph

(f) For purposes of this subdivision, "medical institution" means a skilled nursing facility,
intermediate care facility, intermediate care facility for persons with developmental
disabilities, nursing facility, or inpatient hospital.

Sec. 6. Minnesota Statutes 2020, section 256B.0595, subdivision 1, is amended to read:

Subdivision 1. Prohibited transfers. (a) Effective for transfers made after August 10,
1993, an institutionalized person, an institutionalized person's spouse, or any person, court,
or administrative body with legal authority to act in place of, on behalf of, at the direction
of, or upon the request of the institutionalized person or institutionalized person's spouse,
may not give away, sell, or dispose of, for less than fair market value, any asset or interest
therein, except assets other than the homestead that are excluded under the Supplemental
Security Income program, for the purpose of establishing or maintaining medical assistance
eligibility. This applies to all transfers, including those made by a community spouse after
the month in which the institutionalized spouse is determined eligible for medical assistance.

For purposes of determining eligibility for long-term care services, any transfer of such
assets within 36 months before or any time after an institutionalized person requests medical
assistance payment of long-term care services, or 36 months before or any time after a
medical assistance recipient becomes an institutionalized person, for less than fair market
value may be considered. Any such transfer is presumed to have been made for the purpose
of establishing or maintaining medical assistance eligibility and the institutionalized person
is ineligible for long-term care services for the period of time determined under subdivision
2, unless the institutionalized person furnishes convincing evidence to establish that the
transaction was exclusively for another purpose, or unless the transfer is permitted under
subdivision 3 or 4. In the case of payments from a trust or portions of a trust that are
considered transfers of assets under federal law, or in the case of any other disposal of assets
made on or after February 8, 2006, any transfers made within 60 months before or any time
after an institutionalized person requests medical assistance payment of long-term care
services and within 60 months before or any time after a medical assistance recipient becomes
an institutionalized person, may be considered.
(b) This section applies to transfers, for less than fair market value, of income or assets,
including assets that are considered income in the month received, such as inheritances,
court settlements, and retroactive benefit payments or income to which the institutionalized
person or the institutionalized person's spouse is entitled but does not receive due to action
by the institutionalized person, the institutionalized person's spouse, or any person, court,
or administrative body with legal authority to act in place of, on behalf of, at the direction
of, or upon the request of the institutionalized person or the institutionalized person's spouse.
(c) This section applies to payments for care or personal services provided by a relative,
unless the compensation was stipulated in a notarized, written agreement which was
in existence when the service was performed, the care or services directly benefited the
person, and the payments made represented reasonable compensation for the care or services
provided. A notarized written agreement is not required if payment for the services was
made within 60 days after the service was provided.
(d) This section applies to the portion of any asset or interest that an institutionalized
person, an institutionalized person's spouse, or any person, court, or administrative body
with legal authority to act in place of, on behalf of, at the direction of, or upon the request
of the institutionalized person or the institutionalized person's spouse, transfers to any
annuity that exceeds the value of the benefits likely to be returned to the institutionalized
person or institutionalized person's spouse while alive, based on estimated life expectancy
as determined according to the current actuarial tables published by the Office of the Chief
Actuary of the Social Security Administration. The commissioner may adopt rules reducing
life expectancies based on the need for long-term care. This section applies to an annuity
purchased on or after March 1, 2002, that:
1) is not purchased from an insurance company or financial institution that is subject
to licensing or regulation by the Minnesota Department of Commerce or a similar regulatory
agency of another state;
2) does not pay out principal and interest in equal monthly installments;
3) does not begin payment at the earliest possible date after annuitization.
4) Effective for transactions, including the purchase of an annuity, occurring on or
after February 8, 2006, by or on behalf of an institutionalized person who has applied for
or is receiving long-term care services or the institutionalized person's spouse shall be treated
as the disposal of an asset for less than fair market value unless the department is named a
preferred remainder beneficiary as described in section 256B.056, subdivision 11. Any
subsequent change to the designation of the department as a preferred remainder beneficiary
shall result in the annuity being treated as a disposal of assets for less than fair market value.
The amount of such transfer shall be the maximum amount the institutionalized person or
the institutionalized person's spouse could receive from the annuity or similar financial
instrument. Any change in the amount of the income or principal being withdrawn from the
annuity or other similar financial instrument at the time of the most recent disclosure shall
be deemed to be a transfer of assets for less than fair market value unless the institutionalized
person or the institutionalized person's spouse demonstrates that the transaction was for fair
market value. In the event a distribution of income or principal has been improperly
distributed or disbursed from an annuity or other retirement planning instrument of an
institutionalized person or the institutionalized person's spouse, a cause of action exists
against the individual receiving the improper distribution for the cost of medical assistance
services provided or the amount of the improper distribution, whichever is less.

Effective for transactions, including the purchase of an annuity, occurring on or
after February 8, 2006, by or on behalf of an institutionalized person applying for or receiving
long-term care services shall be treated as a disposal of assets for less than fair market value
unless it is:
(1) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue
Code of 1986; or
(2) purchased with proceeds from:
   (i) an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal
       Revenue Code;
   (ii) a simplified employee pension within the meaning of section 408(k) of the Internal
       Revenue Code; or
   (iii) a Roth IRA described in section 408A of the Internal Revenue Code; or
(3) an annuity that is irrevocable and nonassignable; is actuarially sound as determined
   in accordance with actuarial publications of the Office of the Chief Actuary of the Social
   Security Administration; and provides for payments in equal amounts during the term of
   the annuity, with no deferral and no balloon payments made.

For purposes of this section, long-term care services include services in a nursing
facility, services that are eligible for payment according to section 256B.0025, subdivision
2, because they are provided in a swing bed, intermediate care facility for persons with
developmental disabilities, and home and community-based services provided pursuant to
chapter 256S and sections 256B.092 and 256B.49. For purposes of this subdivision and
subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in
a nursing facility or in a swing bed, or intermediate care facility for persons with
developmental disabilities or who is receiving home and community-based services under
chapter 256S and sections 256B.092 and 256B.49.
This section applies to funds used to purchase a promissory note, loan, or mortgage unless the note, loan, or mortgage:

(1) has a repayment term that is actuarially sound;

(2) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(3) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not meet an exception in paragraph (g), clauses (1) to (3), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the institutionalized person's request for medical assistance payment of long-term care services.

This section applies to the purchase of a life estate interest in another person's home unless the purchaser resides in the home for a period of at least one year after the date of purchase.

This section applies to transfers into a pooled trust that qualifies under United States Code, title 42, section 1396p(d)(4)(C), by:

(1) a person age 65 or older or the person's spouse; or

(2) any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of a person age 65 or older or the person's spouse.

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

Sec. 7. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. Telehealth services. (a) Medical assistance covers medically necessary services and consultations delivered by a health care provider through telehealth in the same manner as if the service or consultation was delivered through in-person contact. Services or consultations delivered through telehealth shall be paid at the full allowable rate.

(b) The commissioner may establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service through telehealth. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide through telehealth;

(2) has written policies and procedures specific to services delivered through telehealth that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the service is delivered through telehealth;
(4) has established protocols addressing how and when to discontinue telehealth services; and

(5) has an established quality assurance process related to delivering services through telehealth.

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

(1) the type of service delivered through telehealth;

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

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

(4) the mode of transmission used to deliver the service through telehealth and records evidencing that a particular mode of transmission was utilized;

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

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

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

(d) Telehealth visits, as described in this subdivision provided through audio and visual communication, may be used to satisfy the face-to-face requirement for reimbursement under the payment methods that apply to a federally qualified health center, rural health clinic, Indian health service, 638 Tribal clinic, and certified community behavioral health clinic, if the service would have otherwise qualified for payment if performed in person.

(e) For mental health services or assessments delivered through telehealth that are based on an individual treatment plan, the provider may document the client's verbal approval or electronic written approval of the treatment plan or change in the treatment plan in lieu of the client's signature in accordance with Minnesota Rules, part 9505.0371.

(f) For purposes of this subdivision, unless otherwise covered under this chapter:

(1) "telehealth" means the delivery of health care services or consultations through the usual using real-time two-way interactive audio and visual communication or accessible telemedicine video-based platforms to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a
patient's health care. Telehealth includes the application of secure video conferencing,
consisting of a real-time, full-motion synchronized video; store-and-forward technology;
and synchronous interactions between a patient located at an originating site and a health
care provider located at a distant site. Telehealth does not include communication between
health care providers, or between a health care provider and a patient that consists solely
of an audio-only communication, e-mail, or facsimile transmission or as specified by law;

(2) "health care provider" means:

(i) a health care provider as defined under section 62A.673;

(ii) a community paramedic as defined under section 144E.001, subdivision 5;

(iii) a community health worker who meets the criteria under subdivision 49, paragraph

(a);

(iv) a mental health certified peer specialist under section 256B.0615, subdivision 5;

(v) a mental health certified family peer specialist under section 256B.0616, subdivision

5;

(vi) a mental health rehabilitation worker under section 256B.0623, subdivision 5, paragraph (a), clause (4), and paragraph (b);

(vii) a mental health behavioral aide under section 256B.0943, subdivision 7, paragraph

(b), clause (3);

(viii) a treatment coordinator under section 245G.11, subdivision 7;

(ix) an alcohol and drug counselor under section 245G.11, subdivision 5 or

(x) a recovery peer under section 245G.11, subdivision 8; and

(3) "originating site," "distant site," and "store-and-forward technology" have the
meanings given in section 62A.673, subdivision 2.

Sec. 8. Minnesota Statutes 2020, section 256B.0625, subdivision 64, is amended to read:

Subd. 64. Investigational drugs, biological products, devices, and clinical
trials. Medical assistance and the early periodic screening, diagnosis, and treatment (EPSDT)
program do not cover the costs of any services that are incidental to, associated with, or
resulting from the use of investigational drugs, biological products, or devices as defined
in section 151.375 or any other treatment that is part of an approved clinical trial as defined
in section 62Q.526. Participation of an enrollee in an approved clinical trial does not preclude
coverage of medically necessary services covered under this chapter that are not related to
the approved clinical trial. Any items or services that are provided solely to satisfy data
collection and analysis for a clinical trial, and not for direct clinical management of the
enrollee, are not covered.
Sec. 8. Minnesota Statutes 2021 Supplement, section 256B.69, subdivision 9f, is amended to read:

Subd. 9f. Annual report on provider reimbursement rates. (a) The commissioner, by December 15 of each year, beginning December 15, 2021, 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.

(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 if within the county there are more than three medical assistance enrolled providers providing the specific service within the specific category:

1. physician prenatal services;
2. physician preventive services;
3. physician services other than prenatal or preventive;
4. dental services;
5. inpatient hospital services;
6. outpatient hospital services;
7. mental health services; and
8. substance use disorder services.

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

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).
(b) “Adverse benefit determination” has the meaning provided in Code of Federal Regulations, title 42, section 438.400, subpart (b).

(c) “Appeal” means an oral or written request from an enrollee to the managed care organization for review of an adverse benefit determination.

(d) “Commissioner” means the commissioner of human services.

(e) “Complaint” means an enrollee's informal expression of dissatisfaction about any matter relating to the enrollee's prepaid health plan other than an adverse benefit determination.

(f) “Data analyst” means the person employed by the ombudsperson that uses research methodologies to conduct research on data collected from prepaid health plans, including but not limited to scientific theory; hypothesis testing; survey research techniques; data collection; data manipulation; and statistical analysis interpretation, including multiple regression techniques.

(g) “Enrollee” means a person enrolled in a prepaid health plan under section 256B.69. When applicable, an enrollee includes an enrollee's authorized representative.

(h) “External review” means the process described under Code of Federal Regulations, title 42, part 438, subpart (f).

(i) “Grievance” means an enrollee's expression of dissatisfaction about any matter relating to the enrollee's prepaid health plan other than an adverse benefit determination that follows the procedures outlined in Code of Federal Regulations, title 42, part 438, subpart (f). A grievance may include but is not limited to concerns relating to quality of care, services provided, or failure to respect an enrollee's rights under a prepaid health plan.

(j) “Managed care advocate” means a county or Tribal employee who works with managed care enrollees when the enrollee has service, billing, or access problems with the enrollee's prepaid health plan.

(k) “Prepaid health plan” means a plan under contract with the commissioner according to section 256B.69.

(l) “State fair hearing” means the appeals process mandated under section 256.045, subdivision 3a.

Subd. 2. Ombudsperson. The commissioner must designate an ombudsperson to advocate for enrollees. At the time of enrollment in a prepaid health plan, the local agency must inform enrollees about the ombudsperson.

Subd. 3. Duties and cost. (a) The ombudsperson must work to ensure enrollees receive covered services as described in the enrollee's prepaid health plan by:
267.30 (1) providing assistance and education to enrollees, when requested, regarding covered
267.31 health care benefits or services; billing and access; or the grievance, appeal, or state fair
267.32 hearing processes;
268.1 (2) with the enrollee's permission and within the ombudsperson's discretion, using an
268.2 informal review process to assist an enrollee with a resolution involving the enrollee's
268.3 prepaid health plan's benefits;
268.4 (3) assisting enrollees, when requested, with prepaid health plan grievances, appeals, or
268.5 the state fair hearing process;
268.6 (4) overseeing, reviewing, and approving documents used by enrollees relating to prepaid
268.7 health plans' grievances, appeals, and state fair hearings;
268.8 (5) reviewing all state fair hearings and requests by enrollees for external review;
268.9 overseeing entities under contract to provide external reviews, processes, and payments for
268.10 services; and utilizing aggregated results of external reviews to recommend health care
268.11 benefits policy changes; and
268.12 (6) providing trainings to managed care advocates.
268.13 (b) The ombudsperson must not charge an enrollee for the ombudsperson's services.
268.14 Subd. 4. Powers. In exercising the ombudsperson's authority under this section, the
268.15 ombudsperson may:
268.16 (1) gather information and evaluate any practice, policy, procedure, or action by a prepaid
268.17 health plan, state human services agency, county, or Tribe; and
268.18 (2) prescribe the methods by which complaints are to be made, received, and acted upon.
268.19 The ombudsperson's authority under this clause includes but is not limited to:
268.20 (i) determining the scope and manner of a complaint;
268.21 (ii) holding a prepaid health plan accountable to address a complaint in a timely manner
268.22 as outlined in state and federal laws;
268.23 (iii) requiring a prepaid health plan to respond in a timely manner to a request for data,
268.24 case details, and other information as needed to help resolve a complaint or to improve a
268.25 prepaid health plan's policy; and
268.26 (iv) making recommendations for policy, administrative, or legislative changes regarding
268.27 prepaid health plans to the proper partners;
268.28 Subd. 5. Data. (a) The data analyst must review and analyze prepaid health plan data
268.29 on denial, termination, and reduction notices (DTRs), grievances, appeals, and state fair
268.30 hearings by:
(1) analyzing, reviewing, and reporting on DTRs, grievances, appeals, and state fair
hearings data collected from each prepaid health plan;

(2) collaborating with the commissioner's partners and the Department of Health for the
Triennial Compliance Assessment under Code of Federal Regulations, title 42, section
438.358, subpart (b);

(3) reviewing state fair hearing decisions for policy or coverage issues that may affect
enrollees; and

(4) providing data required under Code of Federal Regulations, title 42, section 438.66
(2016), to the Centers for Medicare and Medicaid Services.

(b) The data analyst must share the data analyst's data observations and trends under
this subdivision with the ombudsperson, prepaid health plans, and commissioner's partners.

Subd. 6. Collaboration and independence. (a) The ombudsperson must work in
collaboration with the commissioner and the commissioner's partners when the
ombudsperson's collaboration does not otherwise interfere with the ombudsperson's duties
under this section.

(b) The ombudsperson may act independently of the commissioner when:

(1) providing information or testimony to the legislature; and

(2) contacting and making reports to federal and state officials.

Subd. 7. Civil actions. The ombudsperson is not civilly liable for actions taken under
this section if the action was taken in good faith, was within the scope of the ombudsperson's
authority, and did not constitute willful or reckless misconduct.

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

Sec. 10. Minnesota Statutes 2020, section 256B.77, subdivision 13, is amended to read:

Subd. 13. Ombudsman. Enrollees shall have access to ombudsman services established
in section 256D.6903, and advocacy services provided by the
ombudsman for mental health and developmental disabilities established in sections 245.91
to 245.97. The managed care ombudsman and the ombudsman for mental health and
developmental disabilities shall coordinate services provided to avoid duplication of services.
For purposes of the demonstration project, the powers and responsibilities of the Office of
Ombudsman for Mental Health and Developmental Disabilities, as provided in sections
245.91 to 245.97 are expanded to include all eligible individuals, health plan companies,
agencies, and providers participating in the demonstration project.
Sec. 11. REPEALER.

(a) Minnesota Statutes 2020, section 256B.057, subdivision 7, is repealed on July 1, 2022.

(b) Minnesota Statutes 2020, sections 256B.69, subdivision 20; 501C.0408, subdivision 4; and 501C.1206, are repealed the day following final enactment.