18.10 **ARTICLE 2**

18.11 **DEPARTMENT OF HUMAN SERVICES HEALTH CARE POLICY**

18.12 Section 1. Minnesota Statutes 2022, section 62M.01, subdivision 3, is amended to read:

18.13 Subd. 3. **Scope.** (a) Nothing in this chapter applies to review of claims after submission
18.14 to determine eligibility for benefits under a health benefit plan. The appeal procedure
18.15 described in section 62M.06 applies to any complaint as defined under section 62Q.68,
18.16 subdivision 2, that requires a medical determination in its resolution.

18.17 (b) Effective January 1, 2026, this chapter does not apply applies to managed care plans
18.18 or county-based purchasing plans when the plan is providing coverage to state public health
18.19 care program enrollees under chapter 256B or 256L.

18.20 (c) Effective January 1, 2026, the following sections of this chapter apply to services
18.21 delivered through fee-for-service under chapters 256B and 256L: sections 62M.02,
18.22 subdivisions 1 to 5, 7 to 12, 13, 14 to 18, and 21; 62M.04; 62M.05, subdivisions 1 to 4;
18.23 62M.06, subdivisions 1 to 3; 62M.07; 62M.072; 62M.09; 62M.10; 62M.12; and 62M.17,
18.24 subdivision 2.

18.25 Sec. 2. Minnesota Statutes 2023 Supplement, section 256.0471, subdivision 1, as amended
18.26 by Laws 2024, chapter 80, article 1, section 76, is amended to read:

18.27 Subdivision 1. **Qualifying overpayment.** Any overpayment for state-funded medical
18.28 assistance under chapter 256B and state-funded MinnesotaCare under chapter 256L granted
18.29 pursuant to section 256.045, subdivision 10; chapter 256B for state-funded medical
18.30 assistance; and chapters 256D, 256I, 256K, and 256L for state-funded MinnesotaCare except
18.31 agency error claims, become a judgment by operation of law 90 days after the notice of
18.32 overpayment is personally served upon the recipient in a manner that is sufficient under
19.1 rule 4.03(a) of the Rules of Civil Procedure for district courts, or by certified mail, return
19.2 receipt requested. This judgment shall be entitled to full faith and credit in this and any
19.3 other state.

19.4 **EFFECTIVE DATE.** This section is effective July 1, 2024.

19.5 Sec. 3. Minnesota Statutes 2022, section 256.9657, subdivision 8, is amended to read:

19.6 Subd. 8. **Commissioner's duties.** (a) Beginning October 1, 2023, the commissioner of
19.7 human services shall annually report to the chairs and ranking minority members of the
19.8 legislative committees with jurisdiction over health care policy and finance regarding the
19.9 provider surcharge program. The report shall include information on total billings, total

21.16 **ARTICLE 2**

21.17 **DEPARTMENT OF HUMAN SERVICES HEALTH CARE POLICY**

THE FOLLOWIING LANGAUGE IS FROM HOUSE ARTICLE 4, SECTION 16.

65.12 Sec. 16. Minnesota Statutes 2022, section 62M.01, subdivision 3, is amended to read:

65.13 Subd. 3. **Scope.** (a) Nothing in this chapter applies to review of claims after submission
65.14 to determine eligibility for benefits under a health benefit plan. The appeal procedure
65.15 described in section 62M.06 applies to any complaint as defined under section 62Q.68,
65.16 subdivision 2, that requires a medical determination in its resolution.

65.17 (b) Effective January 1, 2026, this chapter does not apply applies to managed care plans
65.18 or county-based purchasing plans when the plan is providing coverage to state public health
65.19 care program enrollees under chapter 256B or 256L.

65.20 (c) Effective January 1, 2026, the following sections of this chapter apply to services
65.21 delivered through fee-for-service under chapters 256B and 256L: 62M.02, subdivisions 1
65.22 to 5, 7 to 12, 13, 14 to 18, and 21; 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions
65.23 1 to 3; 62M.07; 62M.072; 62M.09; 62M.10; 62M.12; 62M.17, subdivision 2; and 62M.18.
65.24 The commissioner shall comply with the requirements of section 62M.18 using existing
65.25 appropriations.

21.18 Section 1. Minnesota Statutes 2023 Supplement, section 256.0471, subdivision 1, as
21.19 amended by Laws 2024, chapter 80, article 1, section 76, is amended to read:

21.20 Subdivision 1. **Qualifying overpayment.** Any overpayment for state-funded medical
21.21 assistance under chapter 256B and state-funded MinnesotaCare under chapter 256L granted
21.22 pursuant to section 256.045, subdivision 10; chapter 256B for state-funded medical
21.23 assistance; and for assistance granted under chapters 256D, 256I, and 256K, and 256L for
21.24 state-funded MinnesotaCare except agency error claims, become a judgment by operation
21.25 of law 90 days after the notice of overpayment is personally served upon the recipient in a
21.26 manner that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts,
21.27 or by certified mail, return receipt requested. This judgment shall be entitled to full faith
21.28 and credit in this and any other state.

21.29 **EFFECTIVE DATE.** This section is effective July 1, 2024.

22.1 Sec. 2. Minnesota Statutes 2022, section 256.9657, subdivision 8, is amended to read:

22.2 Subd. 8. **Commissioner's duties.** (a) Beginning October 1, 2023, the commissioner of
22.3 human services shall annually report to the chairs and ranking minority members of the
22.4 legislative committees with jurisdiction over health care policy and finance regarding the
22.5 provider surcharge program. The report shall include information on total billings, total

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~~collections, and administrative expenditures for the previous fiscal year. This paragraph expires January 1, 2032.~~

~~(b)~~ (a) The surcharge shall be adjusted by inflationary and caseload changes in future bienniums to maintain reimbursement of health care providers in accordance with the requirements of the state and federal laws governing the medical assistance program, including the requirements of the Medicaid moratorium amendments of 1991 found in Public Law No. 102-234.

~~(c)~~ (b) The commissioner shall request the Minnesota congressional delegation to support a change in federal law that would prohibit federal disallowances for any state that makes a good faith effort to comply with Public Law 102-234 by enacting conforming legislation prior to the issuance of federal implementing regulations.

Sec. 4. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to read:

Subd. 2h. **Alternate inpatient payment rate for a discharge.** (a) Effective retroactively from January 1, 2024, in any rate year in which a children's hospital discharge is included in the federally required disproportionate share hospital payment audit, where the patient discharged had resided in a children's hospital for over 20 years, the commissioner shall compute an alternate inpatient rate for the children's hospital. The alternate payment rate must be the rate computed under this section excluding the disproportionate share hospital payment under subdivision 9, paragraph (d), clause (1), increased by an amount equal to 99 percent of what the disproportionate share hospital payment would have been under subdivision 9, paragraph (d), clause (1), had the discharge been excluded.

(b) In any rate year in which payment to a children's hospital is made using this alternate payment rate, payments must not be made to the hospital under subdivisions 2e, 2f, and 9.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. Minnesota Statutes 2022, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. **Income and assets generally.** (a)(1) Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the Supplemental Security Income program shall be used, except as provided ~~under~~ in clause (2) and subdivision 3, paragraph (a), clause (6).

(2) State tax credits, rebates, and refunds must not be counted as income. State tax credits, rebates, and refunds must not be counted as assets for a period of 12 months after the month of receipt.

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~~collections, and administrative expenditures for the previous fiscal year. This paragraph expires January 1, 2032.~~

~~(b)~~ (a) The surcharge shall be adjusted by inflationary and caseload changes in future bienniums to maintain reimbursement of health care providers in accordance with the requirements of the state and federal laws governing the medical assistance program, including the requirements of the Medicaid moratorium amendments of 1991 found in Public Law No. 102-234.

~~(c)~~ (b) The commissioner shall request the Minnesota congressional delegation to support a change in federal law that would prohibit federal disallowances for any state that makes a good faith effort to comply with Public Law 102-234 by enacting conforming legislation prior to the issuance of federal implementing regulations.

THE FOLLOWING LANGUAGE IS FROM HOUSE ARTICLE 1, SECTION 6.

Sec. 6. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to read:

Subd. 2h. **Alternate inpatient payment rate for a discharge.** (a) Effective retroactively from January 1, 2024, in any rate year in which a children's hospital discharge is included in the federally required disproportionate share hospital payment audit where the patient discharged had resided in a children's hospital for over 20 years, the commissioner shall compute an alternate inpatient rate for the children's hospital. The alternate payment rate must be the rate computed under this section excluding the disproportionate share hospital payment under subdivision 9, paragraph (d), clause (1), increased by an amount equal to 99 percent of what the disproportionate share hospital payment would have been under subdivision 9, paragraph (d), clause (1), had the discharge been excluded.

(b) In any rate year in which payment to a children's hospital is made using this alternate payment rate, payments must not be made to the hospital under subdivisions 2e, 2f, and 9.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2022, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. **Income and assets generally.** (a)(1) Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the Supplemental Security Income program shall be used, except as provided ~~under~~ in clause (2) and subdivision 3, paragraph (a), clause (6).

(2) State tax credits, rebates, and refunds must not be counted as income. State tax credits, rebates, and refunds must not be counted as assets for a period of 12 months after the month of receipt.

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~~(2)~~ (3) 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 upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, and Social Security payments are not counted as income.

(b)(1) The modified adjusted gross income methodology as defined in United States Code, title 42, section 1396a(e)(14), shall be used for eligibility categories based on:

(i) children under age 19 and their parents and relative caretakers as defined in section 256B.055, subdivision 3a;

(ii) children ages 19 to 20 as defined in section 256B.055, subdivision 16;

(iii) pregnant women as defined in section 256B.055, subdivision 6;

(iv) infants as defined in sections 256B.055, subdivision 10, and 256B.057, subdivision 1; and

(v) adults without children as defined in section 256B.055, subdivision 15.

For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

(2) For individuals whose income eligibility is determined using the modified adjusted gross income methodology in clause (1):

(i) the commissioner shall subtract from the individual's modified adjusted gross income an amount equivalent to five percent of the federal poverty guidelines; and

(ii) the individual's current monthly income and household size is used to determine eligibility for the 12-month eligibility period. If an individual's income is expected to vary month to month, eligibility is determined based on the income predicted for the 12-month eligibility period.

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

Sec. 6. Minnesota Statutes 2022, 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 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

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~~(2)~~ (3) 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 upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, and Social Security payments are not counted as income.

(b)(1) The modified adjusted gross income methodology as defined in United States Code, title 42, section 1396a(e)(14), shall be used for eligibility categories based on:

(i) children under age 19 and their parents and relative caretakers as defined in section 256B.055, subdivision 3a;

(ii) children ages 19 to 20 as defined in section 256B.055, subdivision 16;

(iii) pregnant women as defined in section 256B.055, subdivision 6;

(iv) infants as defined in sections 256B.055, subdivision 10, and 256B.057, subdivision 1; and

(v) adults without children as defined in section 256B.055, subdivision 15.

For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

(2) For individuals whose income eligibility is determined using the modified adjusted gross income methodology in clause (1):

(i) the commissioner shall subtract from the individual's modified adjusted gross income an amount equivalent to five percent of the federal poverty guidelines; and

(ii) the individual's current monthly income and household size is used to determine eligibility for the 12-month eligibility period. If an individual's income is expected to vary month to month, eligibility is determined based on the income predicted for the 12-month eligibility period.

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

Sec. 4. Minnesota Statutes 2022, 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 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

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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~~ verify assets 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~~ verify assets 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.

Sec. 7. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 8, is amended to read:

Subd. 8. **Medical assistance payment for assertive community treatment and intensive residential treatment services.** (a) Payment for intensive residential treatment services and assertive community treatment in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

(b) Except as indicated in paragraph (c), payment will not be made to more than one entity for each client for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.

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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~~ verify assets 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~~ verify assets 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.

THE FOLLOWING LANGUAGE WAS MOVED IN FROM HOUSE ARTICLE 9, SECTION 18.

Sec. 18. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 8, is amended to read:

Subd. 8. **Medical assistance payment for assertive community treatment and intensive residential treatment services.** (a) Payment for intensive residential treatment services and assertive community treatment in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

(b) Except as indicated in paragraph (c), payment will not be made to more than one entity for each client for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.

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22.20 (c) The commissioner shall determine one rate for each provider that will bill medical
22.21 assistance for residential services under this section and one rate for each assertive community
22.22 treatment provider. If a single entity provides both services, one rate is established for the
22.23 entity's residential services and another rate for the entity's nonresidential services under
22.24 this section. A provider is not eligible for payment under this section without authorization
22.25 from the commissioner. The commissioner shall develop rates using the following criteria:

22.26 (1) the provider's cost for services shall include direct services costs, other program
22.27 costs, and other costs determined as follows:

22.28 (i) the direct services costs must be determined using actual costs of salaries, benefits,
22.29 payroll taxes, and training of direct service staff and service-related transportation;

22.30 (ii) other program costs not included in item (i) must be determined as a specified
22.31 percentage of the direct services costs as determined by item (i). The percentage used shall
22.32 be determined by the commissioner based upon the average of percentages that represent
23.1 the relationship of other program costs to direct services costs among the entities that provide
23.2 similar services;

23.3 (iii) physical plant costs calculated based on the percentage of space within the program
23.4 that is entirely devoted to treatment and programming. This does not include administrative
23.5 or residential space;

23.6 (iv) assertive community treatment physical plant costs must be reimbursed as part of
23.7 the costs described in item (ii); and

23.8 (v) subject to federal approval, up to an additional five percent of the total rate may be
23.9 added to the program rate as a quality incentive based upon the entity meeting performance
23.10 criteria specified by the commissioner;

23.11 (2) actual cost is defined as costs which are allowable, allocable, and reasonable, and
23.12 consistent with federal reimbursement requirements under Code of Federal Regulations,
23.13 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and
23.14 Budget Circular Number A-122, relating to nonprofit entities;

23.15 (3) the number of service units;

23.16 (4) the degree to which clients will receive services other than services under this section;
23.17 and

23.18 (5) the costs of other services that will be separately reimbursed.

23.19 (d) The rate for intensive residential treatment services and assertive community treatment
23.20 must exclude the medical assistance room and board rate, as defined in section 256B.056,
23.21 subdivision 5d, and services not covered under this section, such as partial hospitalization,
23.22 home care, and inpatient services.

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249.16 (c) The commissioner shall determine one rate for each provider that will bill medical
249.17 assistance for residential services under this section and one rate for each assertive community
249.18 treatment provider. If a single entity provides both services, one rate is established for the
249.19 entity's residential services and another rate for the entity's nonresidential services under
249.20 this section. A provider is not eligible for payment under this section without authorization
249.21 from the commissioner. The commissioner shall develop rates using the following criteria:

249.22 (1) the provider's cost for services shall include direct services costs, other program
249.23 costs, and other costs determined as follows:

249.24 (i) the direct services costs must be determined using actual costs of salaries, benefits,
249.25 payroll taxes, and training of direct service staff and service-related transportation;

249.26 (ii) other program costs not included in item (i) must be determined as a specified
249.27 percentage of the direct services costs as determined by item (i). The percentage used shall
249.28 be determined by the commissioner based upon the average of percentages that represent
249.29 the relationship of other program costs to direct services costs among the entities that provide
249.30 similar services;

249.31 (iii) physical plant costs calculated based on the percentage of space within the program
249.32 that is entirely devoted to treatment and programming. This does not include administrative
249.33 or residential space;

250.1 (iv) assertive community treatment physical plant costs must be reimbursed as part of
250.2 the costs described in item (ii); and

250.3 (v) subject to federal approval, up to an additional five percent of the total rate may be
250.4 added to the program rate as a quality incentive based upon the entity meeting performance
250.5 criteria specified by the commissioner;

250.6 (2) actual cost is defined as costs which are allowable, allocable, and reasonable, and
250.7 consistent with federal reimbursement requirements under Code of Federal Regulations,
250.8 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and
250.9 Budget Circular Number A-122, relating to nonprofit entities;

250.10 (3) the number of service units;

250.11 (4) the degree to which clients will receive services other than services under this section;
250.12 and

250.13 (5) the costs of other services that will be separately reimbursed.

250.14 (d) The rate for intensive residential treatment services and assertive community treatment
250.15 must exclude the medical assistance room and board rate, as defined in section 256B.056,
250.16 subdivision 5d, and services not covered under this section, such as partial hospitalization,
250.17 home care, and inpatient services.

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23.23 (e) Physician services that are not separately billed may be included in the rate to the
23.24 extent that a psychiatrist, or other health care professional providing physician services
23.25 within their scope of practice, is a member of the intensive residential treatment services
23.26 treatment team. Physician services, whether billed separately or included in the rate, may
23.27 be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning
23.28 given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth
23.29 is used to provide intensive residential treatment services.

23.30 (f) When services under this section are provided by an assertive community treatment
23.31 provider, case management functions must be an integral part of the team.

24.1 (g) The rate for a provider must not exceed the rate charged by that provider for the
24.2 same service to other payors.

24.3 (h) The rates for existing programs must be established prospectively based upon the
24.4 expenditures and utilization over a prior 12-month period using the criteria established in
24.5 paragraph (c). The rates for new programs must be established based upon estimated
24.6 expenditures and estimated utilization using the criteria established in paragraph (c).

24.7 (i) Effective for the rate years beginning on and after January 1, 2024, rates for assertive
24.8 community treatment, adult residential crisis stabilization services, and intensive residential
24.9 treatment services must be annually adjusted for inflation using the Centers for Medicare
24.10 and Medicaid Services Medicare Economic Index, as forecasted in the ~~fourth~~ third quarter
24.11 of the calendar year before the rate year. The inflation adjustment must be based on the
24.12 12-month period from the midpoint of the previous rate year to the midpoint of the rate year
24.13 for which the rate is being determined.

24.14 (j) Entities who discontinue providing services must be subject to a settle-up process
24.15 whereby actual costs and reimbursement for the previous 12 months are compared. In the
24.16 event that the entity was paid more than the entity's actual costs plus any applicable
24.17 performance-related funding due the provider, the excess payment must be reimbursed to
24.18 the department. If a provider's revenue is less than actual allowed costs due to lower
24.19 utilization than projected, the commissioner may reimburse the provider to recover its actual
24.20 allowable costs. The resulting adjustments by the commissioner must be proportional to the
24.21 percent of total units of service reimbursed by the commissioner and must reflect a difference
24.22 of greater than five percent.

24.23 (k) A provider may request of the commissioner a review of any rate-setting decision
24.24 made under this subdivision.

24.25 Sec. 8. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 9, is amended
24.26 to read:

24.27 Subd. 9. **Dental services.** (a) Medical assistance covers medically necessary dental
24.28 services.

24.29 (b) The following guidelines apply to dental services:

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250.18 (e) Physician services that are not separately billed may be included in the rate to the
250.19 extent that a psychiatrist, or other health care professional providing physician services
250.20 within their scope of practice, is a member of the intensive residential treatment services
250.21 treatment team. Physician services, whether billed separately or included in the rate, may
250.22 be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning
250.23 given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth
250.24 is used to provide intensive residential treatment services.

250.25 (f) When services under this section are provided by an assertive community treatment
250.26 provider, case management functions must be an integral part of the team.

250.27 (g) The rate for a provider must not exceed the rate charged by that provider for the
250.28 same service to other payors.

250.29 (h) The rates for existing programs must be established prospectively based upon the
250.30 expenditures and utilization over a prior 12-month period using the criteria established in
250.31 paragraph (c). The rates for new programs must be established based upon estimated
250.32 expenditures and estimated utilization using the criteria established in paragraph (c).

251.1 (i) Effective for the rate years beginning on and after January 1, 2024, rates for assertive
251.2 community treatment, adult residential crisis stabilization services, and intensive residential
251.3 treatment services must be annually adjusted for inflation using the Centers for Medicare
251.4 and Medicaid Services Medicare Economic Index, as forecasted in the ~~fourth~~ third quarter
251.5 of the calendar year before the rate year. The inflation adjustment must be based on the
251.6 12-month period from the midpoint of the previous rate year to the midpoint of the rate year
251.7 for which the rate is being determined.

251.8 (j) Entities who discontinue providing services must be subject to a settle-up process
251.9 whereby actual costs and reimbursement for the previous 12 months are compared. In the
251.10 event that the entity was paid more than the entity's actual costs plus any applicable
251.11 performance-related funding due the provider, the excess payment must be reimbursed to
251.12 the department. If a provider's revenue is less than actual allowed costs due to lower
251.13 utilization than projected, the commissioner may reimburse the provider to recover its actual
251.14 allowable costs. The resulting adjustments by the commissioner must be proportional to the
251.15 percent of total units of service reimbursed by the commissioner and must reflect a difference
251.16 of greater than five percent.

251.17 (k) A provider may request of the commissioner a review of any rate-setting decision
251.18 made under this subdivision.

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

24.31 (2) application of sealants are covered once every five years per permanent molar; and

24.32 (3) application of fluoride varnish is covered once every six months.

25.1 (c) In addition to the services specified in paragraph ~~(b)~~ (a), medical assistance covers
25.2 the following services:

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

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

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

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

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

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

25.16 Sec. 9. Minnesota Statutes 2022, section 256B.0625, subdivision 12, is amended to read:

25.17 Subd. 12. **Eyeglasses~~, dentures,~~ and prosthetic and orthotic devices.** (a) Medical
25.18 assistance covers eyeglasses~~, dentures,~~ and prosthetic and orthotic devices if prescribed by
25.19 a licensed practitioner.

25.20 (b) For purposes of prescribing prosthetic and orthotic devices, "licensed practitioner"
25.21 includes a physician, an advanced practice registered nurse, a physician assistant, or a
25.22 podiatrist.

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

25.24 Sec. 10. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13e, as
25.25 amended by Laws 2024, chapter 85, section 66, is amended to read:

25.26 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
25.27 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the
25.28 usual and customary price charged to the public. The usual and customary price means the
25.29 lowest price charged by the provider to a patient who pays for the prescription by cash,
25.30 check, or charge account and includes prices the pharmacy charges to a patient enrolled in
25.31 a prescription savings club or prescription discount club administered by the pharmacy or
26.1 pharmacy chain, unless the prescription savings club or prescription discount club is one

26.2 in which an individual pays a recurring monthly access fee for unlimited access to a defined
26.3 list of drugs for which the pharmacy does not bill the member or a payer on a
26.4 per-standard-transaction basis. The amount of payment basis must be reduced to reflect all
26.5 discount amounts applied to the charge by any third-party provider/insurer agreement or
26.6 contract for submitted charges to medical assistance programs. The net submitted charge
26.7 may not be greater than the patient liability for the service. The professional dispensing fee
26.8 shall be $10.77 for prescriptions filled with legend drugs meeting the definition of "covered
26.9 outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The
26.10 dispensing fee for intravenous solutions that must be compounded by the pharmacist shall
26.11 be $10.77 per claim. The professional dispensing fee for prescriptions filled with
26.12 over-the-counter drugs meeting the definition of covered outpatient drugs shall be $10.77
26.13 for dispensed quantities equal to or greater than the number of units contained in the
26.14 manufacturer's original package. The professional dispensing fee shall be prorated based
26.15 on the percentage of the package dispensed when the pharmacy dispenses a quantity less
26.16 than the number of units contained in the manufacturer's original package. The pharmacy
26.17 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered
26.18 outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units
26.19 contained in the manufacturer's original package and shall be prorated based on the
26.20 percentage of the package dispensed when the pharmacy dispenses a quantity less than the
26.21 number of units contained in the manufacturer's original package. The National Average
26.22 Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug.
26.23 For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient
26.24 cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for
26.25 a provider participating in the federal 340B Drug Pricing Program shall be either the 340B
26.26 Drug Pricing Program ceiling price established by the Health Resources and Services
26.27 Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as
26.28 the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in
26.29 the United States, not including prompt pay or other discounts, rebates, or reductions in
26.30 price, for the most recent month for which information is available, as reported in wholesale
26.31 price guides or other publications of drug or biological pricing data. The maximum allowable
26.32 cost of a multisource drug may be set by the commissioner and it shall be comparable to
26.33 the actual acquisition cost of the drug product and no higher than the NADAC of the generic
26.34 product. Establishment of the amount of payment for drugs shall not be subject to the
26.35 requirements of the Administrative Procedure Act.

27.1 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
27.2 an automated drug distribution system meeting the requirements of section 151.58, or a
27.3 packaging system meeting the packaging standards set forth in Minnesota Rules, part
27.4 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
27.5 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
27.6 retrospectively billing pharmacy must submit a claim only for the quantity of medication
27.7 used by the enrolled recipient during the defined billing period. A retrospectively billing
27.8 pharmacy must use a billing period not less than one calendar month or 30 days.

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

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

27.20 (e) The basis for determining the amount of payment for drugs administered in an
27.21 outpatient setting shall be the lower of the usual and customary cost submitted by the
27.22 provider, 106 percent of the average sales price as determined by the United States
27.23 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
27.24 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
27.25 set by the commissioner. If average sales price is unavailable, the amount of payment must
27.26 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
27.27 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
27.28 The commissioner shall discount the payment rate for drugs obtained through the federal
27.29 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an
27.30 outpatient setting shall be made to the administering facility or practitioner. A retail or
27.31 specialty pharmacy dispensing a drug for administration in an outpatient setting is not
27.32 eligible for direct reimbursement.

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

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

28.18 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey
28.19 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient
28.20 drugs under medical assistance. The commissioner shall ensure that the vendor has prior
28.21 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the
28.22 department to dispense outpatient prescription drugs to fee-for-service members must
28.23 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under
28.24 section 256B.064 for failure to respond. The commissioner shall require the vendor to
28.25 measure a single statewide cost of dispensing for specialty prescription drugs and a single
28.26 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies
28.27 to measure the mean, mean weighted by total prescription volume, mean weighted by
28.28 medical assistance prescription volume, median, median weighted by total prescription
28.29 volume, and median weighted by total medical assistance prescription volume. The
28.30 commissioner shall post a copy of the final cost of dispensing survey report on the
28.31 department's website. The initial survey must be completed no later than January 1, 2021,
28.32 and repeated every three years. The commissioner shall provide a summary of the results
28.33 of each cost of dispensing survey and provide recommendations for any changes to the
28.34 dispensing fee to the chairs and ranking minority members of the legislative committees
29.1 with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section
29.2 256.01, subdivision 42, this paragraph does not expire.

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

29.6 Sec. 11. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
29.7 to read:

29.8 Subd. 25c. **Applicability of utilization review provisions.** Effective January 1, 2026,
29.9 the following provisions of chapter 62M apply to the commissioner when delivering services
29.10 through fee-for-service under chapters 256B and 256L: sections 62M.02, subdivisions 1 to
29.11 5, 7 to 12, 13, 14 to 18, and 21; 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions
29.12 1 to 3; 62M.07; 62M.072; 62M.09; 62M.10; 62M.12; and 62M.17, subdivision 2.

29.13 Sec. 12. Minnesota Statutes 2023 Supplement, section 256B.0701, subdivision 6, is
29.14 amended to read:

29.15 Subd. 6. **Recuperative care facility rate.** (a) The recuperative care facility rate is for
29.16 facility costs and must be paid from state money in an amount equal to the ~~medical assistance~~
29.17 ~~room and board~~ MSA equivalent rate as defined in section 256I.03, subdivision 11a, at the
29.18 time the recuperative care services were provided. The eligibility standards in chapter 256I

THE FOLLOWING LANGUAGE IS FROM HOUSE ARTICLE 4, SECTION 60.

102.10 Sec. 60. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
102.11 to read:

102.12 Subd. 25c. **Applicability of utilization review provisions.** Effective January 1, 2026,
102.13 the following provisions of chapter 62M apply to the commissioner when delivering services
102.14 through fee-for-service under chapters 256B and 256L: 62M.02, subdivisions 1 to 5, 7 to
102.15 12, 13, 14 to 18, and 21; 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions 1 to
102.16 3; 62M.07; 62M.072; 62M.09; 62M.10; 62M.12; and 62M.17, subdivision 2.

24.20 Sec. 5. Minnesota Statutes 2023 Supplement, section 256B.0701, subdivision 6, is amended
24.21 to read:

24.22 Subd. 6. **Recuperative care facility rate.** (a) The recuperative care facility rate is for
24.23 facility costs and must be paid from state money in an amount equal to the ~~medical assistance~~
24.24 ~~room and board~~ MSA equivalent rate as defined in section 256I.03, subdivision 11a, at the
24.25 time the recuperative care services were provided. The eligibility standards in chapter 256I

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29.19 do not apply to the recuperative care facility rate. The recuperative care facility rate is only
29.20 paid when the recuperative care services rate is paid to a provider. Providers may opt to
29.21 only receive the recuperative care services rate.

29.22 (b) Before a recipient is discharged from a recuperative care setting, the provider must
29.23 ensure that the recipient's medical condition is stabilized or that the recipient is being
29.24 discharged to a setting that is able to meet that recipient's needs.

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24.26 do not apply to the recuperative care facility rate. The recuperative care facility rate is only
24.27 paid when the recuperative care services rate is paid to a provider. Providers may opt to
24.28 only receive the recuperative care services rate.

24.29 (b) Before a recipient is discharged from a recuperative care setting, the provider must
24.30 ensure that the recipient's medical condition is stabilized or that the recipient is being
24.31 discharged to a setting that is able to meet that recipient's needs.

25.1 Sec. 6. Minnesota Statutes 2022, section 256B.0757, subdivision 4a, is amended to read:

25.2 Subd. 4a. **Behavioral health home services provider requirements.** A behavioral
25.3 health home services provider must:

25.4 (1) be an enrolled Minnesota Health Care Programs provider;

25.5 (2) provide a medical assistance covered primary care or behavioral health service;

25.6 (3) utilize an electronic health record;

25.7 (4) utilize an electronic patient registry that contains data elements required by the
25.8 commissioner;

25.9 (5) demonstrate the organization's capacity to administer screenings approved by the
25.10 commissioner for substance use disorder or alcohol and tobacco use;

25.11 (6) demonstrate the organization's capacity to refer an individual to resources appropriate
25.12 to the individual's screening results;

25.13 (7) have policies and procedures to track referrals to ensure that the referral met the
25.14 individual's needs;

25.15 (8) conduct a brief needs assessment when an individual begins receiving behavioral
25.16 health home services. The brief needs assessment must be completed with input from the
25.17 individual and the individual's identified supports. The brief needs assessment must address
25.18 the individual's immediate safety and transportation needs and potential barriers to
25.19 participating in behavioral health home services;

25.20 (9) conduct a health wellness assessment within 60 days after intake that contains all
25.21 required elements identified by the commissioner;

25.22 (10) conduct a health action plan that contains all required elements identified by the
25.23 commissioner. The plan must be completed within 90 days after intake and must be updated
25.24 at least once every six months, or more frequently if significant changes to an individual's
25.25 needs or goals occur;

25.26 (11) agree to cooperate with and participate in the state's monitoring and evaluation of
25.27 behavioral health home services; and

25.28 (12) obtain the individual's ~~written~~ consent to begin receiving behavioral health home
25.29 services using a form approved by the commissioner.

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

26.1 Sec. 7. Minnesota Statutes 2022, section 256B.0757, subdivision 4d, is amended to read:

26.2 Subd. 4d. **Behavioral health home services delivery standards.** (a) A behavioral health
26.3 home services provider must meet the following service delivery standards:

26.4 (1) establish and maintain processes to support the coordination of an individual's primary
26.5 care, behavioral health, and dental care;

26.6 (2) maintain a team-based model of care, including regular coordination and
26.7 communication between behavioral health home services team members;

26.8 (3) use evidence-based practices that recognize and are tailored to the medical, social,
26.9 economic, behavioral health, functional impairment, cultural, and environmental factors
26.10 affecting the individual's health and health care choices;

26.11 (4) use person-centered planning practices to ensure the individual's health action plan
26.12 accurately reflects the individual's preferences, goals, resources, and optimal outcomes for
26.13 the individual and the individual's identified supports;

26.14 (5) use the patient registry to identify individuals and population subgroups requiring
26.15 specific levels or types of care and provide or refer the individual to needed treatment,
26.16 intervention, or services;

26.17 (6) ~~utilize the Department of Human Services Partner Portal to~~ identify past and current
26.18 treatment or services and identify potential gaps in care using a tool approved by the
26.19 commissioner;

26.20 (7) deliver services consistent with the standards for frequency and face-to-face contact
26.21 required by the commissioner;

26.22 (8) ensure that a diagnostic assessment is completed for each individual receiving
26.23 behavioral health home services within six months of the start of behavioral health home
26.24 services;

26.25 (9) deliver services in locations and settings that meet the needs of the individual;

26.26 (10) provide a central point of contact to ensure that individuals and the individual's
26.27 identified supports can successfully navigate the array of services that impact the individual's
26.28 health and well-being;

26.29 (11) have capacity to assess an individual's readiness for change and the individual's
26.30 capacity to integrate new health care or community supports into the individual's life;

27.1 (12) offer or facilitate the provision of wellness and prevention education on
27.2 evidenced-based curriculums specific to the prevention and management of common chronic
27.3 conditions;

27.4 (13) help an individual set up and prepare for medical, behavioral health, social service,
27.5 or community support appointments, including accompanying the individual to appointments
27.6 as appropriate, and providing follow-up with the individual after these appointments;

27.7 (14) offer or facilitate the provision of health coaching related to chronic disease
27.8 management and how to navigate complex systems of care to the individual, the individual's
27.9 family, and identified supports;

27.10 (15) connect an individual, the individual's family, and identified supports to appropriate
27.11 support services that help the individual overcome access or service barriers, increase
27.12 self-sufficiency skills, and improve overall health;

27.13 (16) provide effective referrals and timely access to services; and

27.14 (17) establish a continuous quality improvement process for providing behavioral health
27.15 home services.

27.16 (b) The behavioral health home services provider must also create a plan, in partnership
27.17 with the individual and the individual's identified supports, to support the individual after
27.18 discharge from a hospital, residential treatment program, or other setting. The plan must
27.19 include protocols for:

27.20 (1) maintaining contact between the behavioral health home services team member, the
27.21 individual, and the individual's identified supports during and after discharge;

27.22 (2) linking the individual to new resources as needed;

27.23 (3) reestablishing the individual's existing services and community and social supports;
27.24 and

27.25 (4) following up with appropriate entities to transfer or obtain the individual's service
27.26 records as necessary for continued care.

27.27 (c) If the individual is enrolled in a managed care plan, a behavioral health home services
27.28 provider must:

27.29 (1) notify the behavioral health home services contact designated by the managed care
27.30 plan within 30 days of when the individual begins behavioral health home services; and

27.31 (2) adhere to the managed care plan communication and coordination requirements
27.32 described in the behavioral health home services manual.

28.1 (d) Before terminating behavioral health home services, the behavioral health home
28.2 services provider must:

28.3 (1) provide a 60-day notice of termination of behavioral health home services to all
28.4 individuals receiving behavioral health home services, the commissioner, and managed care
28.5 plans, if applicable; and

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29.25 Sec. 13. Minnesota Statutes 2023 Supplement, section 256B.0947, subdivision 7, is
29.26 amended to read:

29.27 Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this
29.28 section must be based on one daily encounter rate per provider inclusive of the following
29.29 services received by an eligible client in a given calendar day: all rehabilitative services,
29.30 supports, and ancillary activities under this section, staff travel time to provide rehabilitative
29.31 services under this section, and crisis response services under section 256B.0624.

30.1 (b) Payment must not be made to more than one entity for each client for services
30.2 provided under this section on a given day. If services under this section are provided by a
30.3 team that includes staff from more than one entity, the team shall determine how to distribute
30.4 the payment among the members.

30.5 (c) The commissioner shall establish regional cost-based rates for entities that will bill
30.6 medical assistance for nonresidential intensive rehabilitative mental health services. In
30.7 developing these rates, the commissioner shall consider:

30.8 (1) the cost for similar services in the health care trade area;

30.9 (2) actual costs incurred by entities providing the services;

30.10 (3) the intensity and frequency of services to be provided to each client;

30.11 (4) the degree to which clients will receive services other than services under this section;
30.12 and

30.13 (5) the costs of other services that will be separately reimbursed.

30.14 (d) The rate for a provider must not exceed the rate charged by that provider for the
30.15 same service to other payers.

30.16 (e) Effective for the rate years beginning on and after January 1, 2024, rates must be
30.17 annually adjusted for inflation using the Centers for Medicare and Medicaid Services
30.18 Medicare Economic Index, as forecasted in the ~~fourth~~ third quarter of the calendar year
30.19 before the rate year. The inflation adjustment must be based on the 12-month period from
30.20 the midpoint of the previous rate year to the midpoint of the rate year for which the rate is
30.21 being determined.

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28.6 (2) refer individuals receiving behavioral health home services to a new behavioral
28.7 health home services provider.

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

THE FOLLOWING LANGUAGE WAS MOVED IN FROM HOUSE ARTICLE 9, SECTION 25.

262.10 Sec. 25. Minnesota Statutes 2023 Supplement, section 256B.0947, subdivision 7, is
262.11 amended to read:

262.12 Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this
262.13 section must be based on one daily encounter rate per provider inclusive of the following
262.14 services received by an eligible client in a given calendar day: all rehabilitative services,
262.15 supports, and ancillary activities under this section, staff travel time to provide rehabilitative
262.16 services under this section, and crisis response services under section 256B.0624.

262.17 (b) Payment must not be made to more than one entity for each client for services
262.18 provided under this section on a given day. If services under this section are provided by a
262.19 team that includes staff from more than one entity, the team shall determine how to distribute
262.20 the payment among the members.

262.21 (c) The commissioner shall establish regional cost-based rates for entities that will bill
262.22 medical assistance for nonresidential intensive rehabilitative mental health services. In
262.23 developing these rates, the commissioner shall consider:

262.24 (1) the cost for similar services in the health care trade area;

262.25 (2) actual costs incurred by entities providing the services;

262.26 (3) the intensity and frequency of services to be provided to each client;

262.27 (4) the degree to which clients will receive services other than services under this section;
262.28 and

262.29 (5) the costs of other services that will be separately reimbursed.

262.30 (d) The rate for a provider must not exceed the rate charged by that provider for the
262.31 same service to other payers.

263.1 (e) Effective for the rate years beginning on and after January 1, 2024, rates must be
263.2 annually adjusted for inflation using the Centers for Medicare and Medicaid Services
263.3 Medicare Economic Index, as forecasted in the ~~fourth~~ third quarter of the calendar year
263.4 before the rate year. The inflation adjustment must be based on the 12-month period from
263.5 the midpoint of the previous rate year to the midpoint of the rate year for which the rate is
263.6 being determined.

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Sec. 14. Minnesota Statutes 2023 Supplement, section 256B.764, is amended to read:

256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.

(a) Effective for services rendered on or after July 1, 2007, payment rates for family planning services shall be increased by 25 percent over the rates in effect June 30, 2007, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1.

(b) Effective for services rendered on or after July 1, 2013, payment rates for family planning services shall be increased by 20 percent over the rates in effect June 30, 2013, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1. The commissioner shall adjust capitation rates to managed care and county-based purchasing plans to reflect this increase, and shall require plans to pass on the full amount of the rate increase to eligible community clinics, in the form of higher payment rates for family planning services.

(c) Effective for services provided on or after January 1, 2024, payment rates for family planning, when such services are provided by an eligible community clinic as defined in section 145.9268, subdivision 1, and abortion services shall be increased by 20 percent. This increase does not apply to federally qualified health centers, rural health centers, or Indian health services.

Sec. 15. Minnesota Statutes 2023 Supplement, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of special education services, home care nursing services, ~~adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services,~~ nonemergency medical transportation services, personal care assistance and case management services, community first services and supports under section 256B.85, behavioral health home services under section 256B.0757, housing stabilization services under section 256B.051, and nursing home or intermediate care facilities services.

(b) Covered health services shall be expanded as provided in this section.

(c) For the purposes of covered health services under this section, "child" means an individual younger than 19 years of age.

Sec. 16. Minnesota Statutes 2022, section 524.3-801, as amended by Laws 2024, chapter 79, article 9, section 20, is amended to read:

524.3-801 NOTICE TO CREDITORS.

(a) Unless notice has already been given under this section, upon appointment of a general personal representative in informal proceedings or upon the filing of a petition for formal appointment of a general personal representative, notice thereof, in the form prescribed

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Sec. 8. Minnesota Statutes 2023 Supplement, section 256B.764, is amended to read:

256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.

(a) Effective for services rendered on or after July 1, 2007, payment rates for family planning services shall be increased by 25 percent over the rates in effect June 30, 2007, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1.

(b) Effective for services rendered on or after July 1, 2013, payment rates for family planning services shall be increased by 20 percent over the rates in effect June 30, 2013, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1. The commissioner shall adjust capitation rates to managed care and county-based purchasing plans to reflect this increase, and shall require plans to pass on the full amount of the rate increase to eligible community clinics, in the form of higher payment rates for family planning services.

(c) Effective for services provided on or after January 1, 2024, payment rates for family planning, when such services are provided by an eligible community clinic as defined in section 145.9268, subdivision 1, and abortion services shall be increased by 20 percent. This increase does not apply to federally qualified health centers, rural health centers, or Indian health services.

Sec. 9. Minnesota Statutes 2023 Supplement, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of special education services, home care nursing services, ~~adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services,~~ nonemergency medical transportation services, personal care assistance and case management services, community first services and supports under section 256B.85, behavioral health home services under section 256B.0757, housing stabilization services under section 256B.051, and nursing home or intermediate care facilities services.

(b) Covered health services shall be expanded as provided in this section.

(c) For the purposes of covered health services under this section, "child" means an individual younger than 19 years of age.

Sec. 10. Minnesota Statutes 2022, section 524.3-801, as amended by Laws 2024, chapter 79, article 9, section 20, is amended to read:

524.3-801 NOTICE TO CREDITORS.

(a) Unless notice has already been given under this section, upon appointment of a general personal representative in informal proceedings or upon the filing of a petition for formal appointment of a general personal representative, notice thereof, in the form prescribed

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by court rule, shall be given under the direction of the court administrator by publication once a week for two successive weeks in a legal newspaper in the county wherein the proceedings are pending giving the name and address of the general personal representative and notifying creditors of the estate to present their claims within four months after the date of the court administrator's notice which is subsequently published or be forever barred, unless they are entitled to further service of notice under paragraph (b) or (c).

(b) The personal representative shall, within three months after the date of the first publication of the notice, serve a copy of the notice upon each then known and identified creditor in the manner provided in paragraph (c). If the decedent or a predeceased spouse of the decedent received assistance for which a claim could be filed under section 246.53, 256B.15, 256D.16, or 261.04, notice to the commissioner of human services or direct care and treatment executive board, as applicable, must be given under paragraph (d) instead of under this paragraph or paragraph (c). A creditor is "known" if: (i) the personal representative knows that the creditor has asserted a claim that arose during the decedent's life against either the decedent or the decedent's estate; (ii) the creditor has asserted a claim that arose during the decedent's life and the fact is clearly disclosed in accessible financial records known and available to the personal representative; or (iii) the claim of the creditor would be revealed by a reasonably diligent search for creditors of the decedent in accessible financial records known and available to the personal representative. Under this section, a creditor is "identified" if the personal representative's knowledge of the name and address of the creditor will permit service of notice to be made under paragraph (c).

(c) Unless the claim has already been presented to the personal representative or paid, the personal representative shall serve a copy of the notice required by paragraph (b) upon each creditor of the decedent who is then known to the personal representative and identified either by delivery of a copy of the required notice to the creditor, or by mailing a copy of the notice to the creditor by certified, registered, or ordinary first class mail addressed to the creditor at the creditor's office or place of residence.

(d)(1) Effective for decedents dying on or after July 1, 1997, if the decedent or a predeceased spouse of the decedent received assistance for which a claim could be filed under section 246.53, 256B.15, 256D.16, or 261.04, the personal representative or the attorney for the personal representative shall serve the commissioner or executive board, as applicable, with notice in the manner prescribed in paragraph (c), or electronically in a manner prescribed by the commissioner or executive board, as soon as practicable after the appointment of the personal representative. The notice must state the decedent's full name, date of birth, and Social Security number and, to the extent then known after making a reasonably diligent inquiry, the full name, date of birth, and Social Security number for each of the decedent's predeceased spouses. The notice may also contain a statement that, after making a reasonably diligent inquiry, the personal representative has determined that the decedent did not have any predeceased spouses or that the personal representative has been unable to determine one or more of the previous items of information for a predeceased spouse of the decedent. A copy of the notice to creditors must be attached to and be a part of the notice to the commissioner or executive board.

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by court rule, shall be given under the direction of the court administrator by publication once a week for two successive weeks in a legal newspaper in the county wherein the proceedings are pending giving the name and address of the general personal representative and notifying creditors of the estate to present their claims within four months after the date of the court administrator's notice which is subsequently published or be forever barred, unless they are entitled to further service of notice under paragraph (b) or (c).

(b) The personal representative shall, within three months after the date of the first publication of the notice, serve a copy of the notice upon each then known and identified creditor in the manner provided in paragraph (c). If the decedent or a predeceased spouse of the decedent received assistance for which a claim could be filed under section 246.53, 256B.15, 256D.16, or 261.04, notice to the commissioner of human services or direct care and treatment executive board, as applicable, must be given under paragraph (d) instead of under this paragraph or paragraph (c). A creditor is "known" if: (i) the personal representative knows that the creditor has asserted a claim that arose during the decedent's life against either the decedent or the decedent's estate; (ii) the creditor has asserted a claim that arose during the decedent's life and the fact is clearly disclosed in accessible financial records known and available to the personal representative; or (iii) the claim of the creditor would be revealed by a reasonably diligent search for creditors of the decedent in accessible financial records known and available to the personal representative. Under this section, a creditor is "identified" if the personal representative's knowledge of the name and address of the creditor will permit service of notice to be made under paragraph (c).

(c) Unless the claim has already been presented to the personal representative or paid, the personal representative shall serve a copy of the notice required by paragraph (b) upon each creditor of the decedent who is then known to the personal representative and identified either by delivery of a copy of the required notice to the creditor, or by mailing a copy of the notice to the creditor by certified, registered, or ordinary first class mail addressed to the creditor at the creditor's office or place of residence.

(d)(1) Effective for decedents dying on or after July 1, 1997, if the decedent or a predeceased spouse of the decedent received assistance for which a claim could be filed under section 246.53, 256B.15, 256D.16, or 261.04, the personal representative or the attorney for the personal representative shall serve the commissioner or executive board, as applicable, with notice in the manner prescribed in paragraph (c), or electronically in a manner prescribed by the commissioner, as soon as practicable after the appointment of the personal representative. The notice must state the decedent's full name, date of birth, and Social Security number and, to the extent then known after making a reasonably diligent inquiry, the full name, date of birth, and Social Security number for each of the decedent's predeceased spouses. The notice may also contain a statement that, after making a reasonably diligent inquiry, the personal representative has determined that the decedent did not have any predeceased spouses or that the personal representative has been unable to determine one or more of the previous items of information for a predeceased spouse of the decedent. A copy of the notice to creditors must be attached to and be a part of the notice to the commissioner or executive board.

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(2) Notwithstanding a will or other instrument or law to the contrary, except as allowed in this paragraph, no property subject to administration by the estate may be distributed by the estate or the personal representative until 70 days after the date the notice is served on the commissioner or executive board as provided in paragraph (c), unless the local agency consents as provided for in clause (6). This restriction on distribution does not apply to the personal representative's sale of real or personal property, but does apply to the net proceeds the estate receives from these sales. The personal representative, or any person with personal knowledge of the facts, may provide an affidavit containing the description of any real or personal property affected by this paragraph and stating facts showing compliance with this paragraph. If the affidavit describes real property, it may be filed or recorded in the office of the county recorder or registrar of titles for the county where the real property is located. This paragraph does not apply to proceedings under sections 524.3-1203 and 525.31, or when a duly authorized agent of a county is acting as the personal representative of the estate.

(3) At any time before an order or decree is entered under section 524.3-1001 or 524.3-1002, or a closing statement is filed under section 524.3-1003, the personal representative or the attorney for the personal representative may serve an amended notice on the commissioner or executive board to add variations or other names of the decedent or a predeceased spouse named in the notice, the name of a predeceased spouse omitted from the notice, to add or correct the date of birth or Social Security number of a decedent or predeceased spouse named in the notice, or to correct any other deficiency in a prior notice. The amended notice must state the decedent's name, date of birth, and Social Security number, the case name, case number, and district court in which the estate is pending, and the date the notice being amended was served on the commissioner or executive board. If the amendment adds the name of a predeceased spouse omitted from the notice, it must also state that spouse's full name, date of birth, and Social Security number. The amended notice must be served on the commissioner or executive board in the same manner as the original notice. Upon service, the amended notice relates back to and is effective from the date the notice it amends was served, and the time for filing claims arising under section 246.53, 256B.15, 256D.16 or 261.04 is extended by 60 days from the date of service of the amended notice. Claims filed during the 60-day period are undischarged and unbarred claims, may be prosecuted by the entities entitled to file those claims in accordance with section 524.3-1004, and the limitations in section 524.3-1006 do not apply. The personal representative or any person with personal knowledge of the facts may provide and file or record an affidavit in the same manner as provided for in clause (1).

(4) Within one year after the date an order or decree is entered under section 524.3-1001 or 524.3-1002 or a closing statement is filed under section 524.3-1003, any person who has an interest in property that was subject to administration by the estate may serve an amended notice on the commissioner or executive board to add variations or other names of the decedent or a predeceased spouse named in the notice, the name of a predeceased spouse omitted from the notice, to add or correct the date of birth or Social Security number of a decedent or predeceased spouse named in the notice, or to correct any other deficiency in

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(2) Notwithstanding a will or other instrument or law to the contrary, except as allowed in this paragraph, no property subject to administration by the estate may be distributed by the estate or the personal representative until 70 days after the date the notice is served on the commissioner or executive board as provided in paragraph (c), unless the local agency consents as provided for in clause (6). This restriction on distribution does not apply to the personal representative's sale of real or personal property, but does apply to the net proceeds the estate receives from these sales. The personal representative, or any person with personal knowledge of the facts, may provide an affidavit containing the description of any real or personal property affected by this paragraph and stating facts showing compliance with this paragraph. If the affidavit describes real property, it may be filed or recorded in the office of the county recorder or registrar of titles for the county where the real property is located. This paragraph does not apply to proceedings under sections 524.3-1203 and 525.31, or when a duly authorized agent of a county is acting as the personal representative of the estate.

(3) At any time before an order or decree is entered under section 524.3-1001 or 524.3-1002, or a closing statement is filed under section 524.3-1003, the personal representative or the attorney for the personal representative may serve an amended notice on the commissioner or executive board to add variations or other names of the decedent or a predeceased spouse named in the notice, the name of a predeceased spouse omitted from the notice, to add or correct the date of birth or Social Security number of a decedent or predeceased spouse named in the notice, or to correct any other deficiency in a prior notice. The amended notice must state the decedent's name, date of birth, and Social Security number, the case name, case number, and district court in which the estate is pending, and the date the notice being amended was served on the commissioner or executive board. If the amendment adds the name of a predeceased spouse omitted from the notice, it must also state that spouse's full name, date of birth, and Social Security number. The amended notice must be served on the commissioner or executive board in the same manner as the original notice. Upon service, the amended notice relates back to and is effective from the date the notice it amends was served, and the time for filing claims arising under section 246.53, 256B.15, 256D.16 or 261.04 is extended by 60 days from the date of service of the amended notice. Claims filed during the 60-day period are undischarged and unbarred claims, may be prosecuted by the entities entitled to file those claims in accordance with section 524.3-1004, and the limitations in section 524.3-1006 do not apply. The personal representative or any person with personal knowledge of the facts may provide and file or record an affidavit in the same manner as provided for in clause (1).

(4) Within one year after the date an order or decree is entered under section 524.3-1001 or 524.3-1002 or a closing statement is filed under section 524.3-1003, any person who has an interest in property that was subject to administration by the estate may serve an amended notice on the commissioner or executive board to add variations or other names of the decedent or a predeceased spouse named in the notice, the name of a predeceased spouse omitted from the notice, to add or correct the date of birth or Social Security number of a decedent or predeceased spouse named in the notice, or to correct any other deficiency in

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34.10 a prior notice. The amended notice must be served on the commissioner or executive board
34.11 in the same manner as the original notice and must contain the information required for
34.12 amendments under clause (3). If the amendment adds the name of a predeceased spouse
34.13 omitted from the notice, it must also state that spouse's full name, date of birth, and Social
34.14 Security number. Upon service, the amended notice relates back to and is effective from
34.15 the date the notice it amends was served. If the amended notice adds the name of an omitted
34.16 predeceased spouse or adds or corrects the Social Security number or date of birth of the
34.17 decedent or a predeceased spouse already named in the notice, then, notwithstanding any
34.18 other laws to the contrary, claims against the decedent's estate on account of those persons
34.19 resulting from the amendment and arising under section 246.53, 256B.15, 256D.16, or
34.20 261.04 are undischarged and unbarred claims, may be prosecuted by the entities entitled to
34.21 file those claims in accordance with section 524.3-1004, and the limitations in section
34.22 524.3-1006 do not apply. The person filing the amendment or any other person with personal
34.23 knowledge of the facts may provide and file or record an affidavit describing affected real
34.24 or personal property in the same manner as clause (1).

34.25 (5) After one year from the date an order or decree is entered under section 524.3-1001
34.26 or 524.3-1002, or a closing statement is filed under section 524.3-1003, no error, omission,
34.27 or defect of any kind in the notice to the commissioner or executive board required under
34.28 this paragraph or in the process of service of the notice on the commissioner or executive
34.29 board, or the failure to serve the commissioner or executive board with notice as required
34.30 by this paragraph, makes any distribution of property by a personal representative void or
34.31 voidable. The distributee's title to the distributed property shall be free of any claims based
34.32 upon a failure to comply with this paragraph.

34.33 (6) The local agency may consent to a personal representative's request to distribute
34.34 property subject to administration by the estate to distributees during the 70-day period after
34.35 service of notice on the commissioner or executive board. The local agency may grant or
35.1 deny the request in whole or in part and may attach conditions to its consent as it deems
35.2 appropriate. When the local agency consents to a distribution, it shall give the estate a written
35.3 certificate evidencing its consent to the early distribution of assets at no cost. The certificate
35.4 must include the name, case number, and district court in which the estate is pending, the
35.5 name of the local agency, describe the specific real or personal property to which the consent
35.6 applies, state that the local agency consents to the distribution of the specific property
35.7 described in the consent during the 70-day period following service of the notice on the
35.8 commissioner or executive board, state that the consent is unconditional or list all of the
35.9 terms and conditions of the consent, be dated, and may include other contents as may be
35.10 appropriate. The certificate must be signed by the director of the local agency or the director's
35.11 designees and is effective as of the date it is dated unless it provides otherwise. The signature
35.12 of the director or the director's designee does not require any acknowledgment. The certificate
35.13 shall be prima facie evidence of the facts it states, may be attached to or combined with a
35.14 deed or any other instrument of conveyance and, when so attached or combined, shall
35.15 constitute a single instrument. If the certificate describes real property, it shall be accepted
35.16 for recording or filing by the county recorder or registrar of titles in the county in which the

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31.29 a prior notice. The amended notice must be served on the commissioner or executive board
31.30 in the same manner as the original notice and must contain the information required for
31.31 amendments under clause (3). If the amendment adds the name of a predeceased spouse
31.32 omitted from the notice, it must also state that spouse's full name, date of birth, and Social
31.33 Security number. Upon service, the amended notice relates back to and is effective from
31.34 the date the notice it amends was served. If the amended notice adds the name of an omitted
31.35 predeceased spouse or adds or corrects the Social Security number or date of birth of the
31.36 decedent or a predeceased spouse already named in the notice, then, notwithstanding any
32.1 other laws to the contrary, claims against the decedent's estate on account of those persons
32.2 resulting from the amendment and arising under section 246.53, 256B.15, 256D.16, or
32.3 261.04 are undischarged and unbarred claims, may be prosecuted by the entities entitled to
32.4 file those claims in accordance with section 524.3-1004, and the limitations in section
32.5 524.3-1006 do not apply. The person filing the amendment or any other person with personal
32.6 knowledge of the facts may provide and file or record an affidavit describing affected real
32.7 or personal property in the same manner as clause (1).

32.8 (5) After one year from the date an order or decree is entered under section 524.3-1001
32.9 or 524.3-1002, or a closing statement is filed under section 524.3-1003, no error, omission,
32.10 or defect of any kind in the notice to the commissioner or executive board required under
32.11 this paragraph or in the process of service of the notice on the commissioner or executive
32.12 board, or the failure to serve the commissioner or executive board with notice as required
32.13 by this paragraph, makes any distribution of property by a personal representative void or
32.14 voidable. The distributee's title to the distributed property shall be free of any claims based
32.15 upon a failure to comply with this paragraph.

32.16 (6) The local agency may consent to a personal representative's request to distribute
32.17 property subject to administration by the estate to distributees during the 70-day period after
32.18 service of notice on the commissioner or executive board. The local agency may grant or
32.19 deny the request in whole or in part and may attach conditions to its consent as it deems
32.20 appropriate. When the local agency consents to a distribution, it shall give the estate a written
32.21 certificate evidencing its consent to the early distribution of assets at no cost. The certificate
32.22 must include the name, case number, and district court in which the estate is pending, the
32.23 name of the local agency, describe the specific real or personal property to which the consent
32.24 applies, state that the local agency consents to the distribution of the specific property
32.25 described in the consent during the 70-day period following service of the notice on the
32.26 commissioner or executive board, state that the consent is unconditional or list all of the
32.27 terms and conditions of the consent, be dated, and may include other contents as may be
32.28 appropriate. The certificate must be signed by the director of the local agency or the director's
32.29 designees and is effective as of the date it is dated unless it provides otherwise. The signature
32.30 of the director or the director's designee does not require any acknowledgment. The certificate
32.31 shall be prima facie evidence of the facts it states, may be attached to or combined with a
32.32 deed or any other instrument of conveyance and, when so attached or combined, shall
32.33 constitute a single instrument. If the certificate describes real property, it shall be accepted
32.34 for recording or filing by the county recorder or registrar of titles in the county in which the

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35.17 property is located. If the certificate describes real property and is not attached to or combined
35.18 with a deed or other instrument of conveyance, it shall be accepted for recording or filing
35.19 by the county recorder or registrar of titles in the county in which the property is located.
35.20 The certificate constitutes a waiver of the 70-day period provided for in clause (2) with
35.21 respect to the property it describes and is prima facie evidence of service of notice on the
35.22 commissioner or executive board. The certificate is not a waiver or relinquishment of any
35.23 claims arising under section 246.53, 256B.15, 256D.16, or 261.04, and does not otherwise
35.24 constitute a waiver of any of the personal representative's duties under this paragraph.
35.25 Distributees who receive property pursuant to a consent to an early distribution shall remain
35.26 liable to creditors of the estate as provided for by law.

35.27 (7) All affidavits provided for under this paragraph:

35.28 (i) shall be provided by persons who have personal knowledge of the facts stated in the
35.29 affidavit;

35.30 (ii) may be filed or recorded in the office of the county recorder or registrar of titles in
35.31 the county in which the real property they describe is located for the purpose of establishing
35.32 compliance with the requirements of this paragraph; and

35.33 (iii) are prima facie evidence of the facts stated in the affidavit.

36.1 (8) This paragraph applies to the estates of decedents dying on or after July 1, 1997.
36.2 Clause (5) also applies with respect to all notices served on the commissioner of human
36.3 services before July 1, 1997, under Laws 1996, chapter 451, article 2, section 55. All notices
36.4 served on the commissioner before July 1, 1997, pursuant to Laws 1996, chapter 451, article
36.5 2, section 55, shall be deemed to be legally sufficient for the purposes for which they were
36.6 intended, notwithstanding any errors, omissions or other defects.

36.7 Sec. 17. **DIRECTION TO COMMISSIONER; REIMBURSEMENT FOR**
36.8 **EXTRACORPOREAL MEMBRANE OXYGENATION CANNULATION AS AN**
36.9 **OUTPATIENT SERVICE.**

36.10 The commissioner of human services, in consultation with providers and hospitals, shall
36.11 determine the feasibility of an outpatient reimbursement mechanism for medical assistance
36.12 coverage of extracorporeal membrane oxygenation (ECMO) cannulation performed outside
36.13 an inpatient hospital setting or in a self-contained mobile ECMO unit. If an outpatient
36.14 reimbursement mechanism is feasible, then the commissioner of human services shall
36.15 develop a recommended payment mechanism. By January 15, 2025, the commissioner of
36.16 human services shall submit a recommendation and the required legislative language to the
36.17 chairs and ranking minority members of the legislative committees with jurisdiction over
36.18 health care finance. If such a payment mechanism is infeasible, the commissioner of human
36.19 services shall submit an explanation as to why it is infeasible.

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32.35 property is located. If the certificate describes real property and is not attached to or combined
33.1 with a deed or other instrument of conveyance, it shall be accepted for recording or filing
33.2 by the county recorder or registrar of titles in the county in which the property is located.
33.3 The certificate constitutes a waiver of the 70-day period provided for in clause (2) with
33.4 respect to the property it describes and is prima facie evidence of service of notice on the
33.5 commissioner or executive board. The certificate is not a waiver or relinquishment of any
33.6 claims arising under section 246.53, 256B.15, 256D.16, or 261.04, and does not otherwise
33.7 constitute a waiver of any of the personal representative's duties under this paragraph.
33.8 Distributees who receive property pursuant to a consent to an early distribution shall remain
33.9 liable to creditors of the estate as provided for by law.

33.10 (7) All affidavits provided for under this paragraph:

33.11 (i) shall be provided by persons who have personal knowledge of the facts stated in the
33.12 affidavit;

33.13 (ii) may be filed or recorded in the office of the county recorder or registrar of titles in
33.14 the county in which the real property they describe is located for the purpose of establishing
33.15 compliance with the requirements of this paragraph; and

33.16 (iii) are prima facie evidence of the facts stated in the affidavit.

33.17 (8) This paragraph applies to the estates of decedents dying on or after July 1, 1997.
33.18 Clause (5) also applies with respect to all notices served on the commissioner of human
33.19 services before July 1, 1997, under Laws 1996, chapter 451, article 2, section 55. All notices
33.20 served on the commissioner before July 1, 1997, pursuant to Laws 1996, chapter 451, article
33.21 2, section 55, shall be deemed to be legally sufficient for the purposes for which they were
33.22 intended, notwithstanding any errors, omissions or other defects.