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ARTICLE 22
HEALTH CARE

373.11 Section 1. Minnesota Statutes 2016, section 3.3005, subdivision 8, is amended to read:

373.12 Subd. 8. **Request contents.** A request to spend federal funds submitted under this section
373.13 must include the name of the federal grant, the federal agency from which the funds are
373.14 available, a federal identification number, a brief description of the purpose of the grant,
373.15 the amounts expected by fiscal year, an indication if any state match is required, an indication
373.16 if there is a maintenance of effort requirement, and the number of full-time equivalent
373.17 positions needed to implement the grant. For new grants, the request must provide a narrative
373.18 description of the short- and long-term commitments required, including whether continuation
373.19 of any full-time equivalent positions will be a condition of receiving the federal award.

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ARTICLE 2
HEALTH CARE

77.6 Section 1. Minnesota Statutes 2017 Supplement, section 13.69, subdivision 1, is amended
77.7 to read:

77.8 Subdivision 1. **Classifications.** (a) The following government data of the Department
77.9 of Public Safety are private data:

77.10 (1) medical data on driving instructors, licensed drivers, and applicants for parking
77.11 certificates and special license plates issued to physically disabled persons;

77.12 (2) other data on holders of a disability certificate under section 169.345, except that (i)
77.13 data that are not medical data may be released to law enforcement agencies, and (ii) data
77.14 necessary for enforcement of sections 169.345 and 169.346 may be released to parking
77.15 enforcement employees or parking enforcement agents of statutory or home rule charter
77.16 cities and towns;

77.17 (3) Social Security numbers in driver's license and motor vehicle registration records,
77.18 except that Social Security numbers must be provided to the Department of Revenue for
77.19 purposes of tax administration, the Department of Labor and Industry for purposes of
77.20 workers' compensation administration and enforcement, the judicial branch for purposes of
77.21 debt collection, and the Department of Natural Resources for purposes of license application
77.22 administration, and except that the last four digits of the Social Security number must be
77.23 provided to the Department of Human Services for purposes of recovery of Minnesota health
77.24 care program benefits paid; and

- 77.25 (4) data on persons listed as standby or temporary custodians under section 171.07,
 77.26 subdivision 11, except that the data must be released to:
- 77.27 (i) law enforcement agencies for the purpose of verifying that an individual is a designated
 77.28 caregiver; or
- 77.29 (ii) law enforcement agencies who state that the license holder is unable to communicate
 77.30 at that time and that the information is necessary for notifying the designated caregiver of
 77.31 the need to care for a child of the license holder.
- 78.1 The department may release the Social Security number only as provided in clause (3)
 78.2 and must not sell or otherwise provide individual Social Security numbers or lists of Social
 78.3 Security numbers for any other purpose.
- 78.4 (b) The following government data of the Department of Public Safety are confidential
 78.5 data: data concerning an individual's driving ability when that data is received from a member
 78.6 of the individual's family.
- 78.7 **EFFECTIVE DATE.** This section is effective July 1, 2018.

HOUSE ARTICLE 2, SECTION 2 IS MATCHED WITH SENATE ARTICLE 24, SECTION 1

HOUSE ARTICLE 2, SECTIONS 3 AND 4 ARE LOCATED IN THE SENATE ARTICLE 24 SIDE BY SIDE.

373.20 Sec. 2. **[62J.90] MINNESOTA HEALTH POLICY COMMISSION.**

373.21 Subdivision 1. **Definition.** For purposes of this section, "commission" means the
 373.22 Minnesota Health Policy Commission.

373.23 Subd. 2. **Commission membership.** The commission shall consist of 15 voting members,
 373.24 appointed by the Legislative Coordinating Commission as provided in subdivision 9, as
 373.25 follows:

373.26 (1) one member with demonstrated expertise in health care finance;

373.27 (2) one member with demonstrated expertise in health economics;

373.28 (3) one member with demonstrated expertise in actuarial science;

- 373.29 (4) one member with demonstrated expertise in health plan management and finance;
- 373.30 (5) one member with demonstrated expertise in health care system management;
- 374.1 (6) one member with demonstrated expertise as a purchaser, or a representative of a
374.2 purchaser, of employer-sponsored health care services or employer-sponsored health
374.3 insurance;
- 374.4 (7) one member with demonstrated expertise in the development and utilization of
374.5 innovative medical technologies;
- 374.6 (8) one member with demonstrated expertise as a health care consumer advocate;
- 374.7 (9) one member who is a primary care physician;
- 374.8 (10) one member who provides long-term care services through medical assistance;
- 374.9 (11) one member with direct experience as an enrollee, or parent or caregiver of an
374.10 enrollee, in MinnesotaCare or medical assistance;
- 374.11 (12) two members of the senate, including one member appointed by the majority leader
374.12 and one member from the minority party appointed by the minority leader; and
- 374.13 (13) two members of the house of representatives, including one member appointed by
374.14 the speaker of the house and one member from the minority party appointed by the minority
374.15 leader.
- 374.16 Subd. 3. **Duties.** (a) The commission shall:
- 374.17 (1) compare Minnesota's private market health care costs and public health care program
374.18 spending to that of the other states;
- 374.19 (2) compare Minnesota's private market health care costs and public health care program
374.20 spending in any given year to its costs and spending in previous years;
- 374.21 (3) identify factors that influence and contribute to Minnesota's ranking for private
374.22 market health care costs and public health care program spending, including the year over
374.23 year and trend line change in total costs and spending in the state;
- 374.24 (4) continually monitor efforts to reform the health care delivery and payment system
374.25 in Minnesota to understand emerging trends in the health insurance market, including the

- 374.26 private health care market, large self-insured employers, and the state's public health care
374.27 programs in order to identify opportunities for state action to achieve:
- 374.28 (i) improved patient experience of care, including quality and satisfaction;
- 374.29 (ii) improved health of all populations; and
- 374.30 (iii) reduced per capita cost of health care;
- 375.1 (5) make recommendations for legislative policy, the health care market, or any other
375.2 reforms to:
- 375.3 (i) lower the rate of growth in private market health care costs and public health care
375.4 program spending in the state;
- 375.5 (ii) positively impact the state's ranking in the areas listed in this subdivision; and
- 375.6 (iii) improve the quality and value of care for all Minnesotans; and
- 375.7 (6) conduct any additional reviews requested by the legislature.
- 375.8 (b) In making recommendations to the legislature, the commission shall consider:
- 375.9 (i) how the recommendations might positively impact the cost-shifting interplay between
375.10 public payer reimbursement rates and health insurance premiums; and
- 375.11 (ii) how public health care programs, where appropriate, may be utilized as a means to
375.12 help prepare enrollees for an eventual transition to the private health care market.
- 375.13 Subd. 4. **Report.** The commission shall submit recommendations for changes in health
375.14 care policy and financing by June 15 each year to the chairs and ranking minority members
375.15 of the legislative committees with primary jurisdiction over health care. The report shall
375.16 include any draft legislation to implement the commission's recommendations.
- 375.17 Subd. 5. **Staff.** The commission shall hire a director who may employ or contract for
375.18 professional and technical assistance as the commission determines necessary to perform
375.19 its duties. The commission may also contract with private entities with expertise in health
375.20 economics, health finance, and actuarial science to secure additional information, data,
375.21 research, or modeling that may be necessary for the commission to carry out its duties.

375.22 Subd. 6. **Access to information.** (a) The commission may request that a state department
375.23 or agency provide the commission with any publicly available information in a usable format
375.24 as requested by the commission, at no cost to the commission.

375.25 (b) The commission may request from a state department or agency unique or custom
375.26 data sets and the department or agency may charge the commission for providing the data
375.27 at the same rate the department or agency would charge any other public or private entity.

375.28 (c) Any information provided to the commission by a state department or agency must
375.29 be de-identified. For purposes of this subdivision, "de-identified" means the process used
375.30 to prevent the identity of a person or business from being connected with information and
375.31 ensuring all identifiable information has been removed.

376.1 Subd. 7. **Terms; vacancies; compensation.** (a) Public members of the commission shall
376.2 serve four-year terms. The public members may not serve for more than two consecutive
376.3 terms.

376.4 (b) The legislative members shall serve on the commission as long as the member or
376.5 the appointing authority holds office.

376.6 (c) The removal of members and filling of vacancies on the commission are as provided
376.7 in section 15.059.

376.8 (d) Public members may receive compensation and expenses as provided in section
376.9 15.059, subdivision 3.

376.10 Subd. 8. **Chairs; officers.** The commission shall elect a chair annually. The commission
376.11 may elect other officers necessary for the performance of its duties.

376.12 Subd. 9. **Selection of members; advisory council.** The Legislative Coordinating
376.13 Commission shall take applications from members of the public who are qualified and
376.14 interested to serve in one of the listed positions. The applications must be reviewed by a
376.15 health policy commission advisory council comprised of four members as follows: the state
376.16 economist, legislative auditor, state demographer, and the president of the Federal Reserve
376.17 Bank of Minneapolis or a designee of the president. The advisory council shall recommend
376.18 two applicants for each of the specified positions by September 30 in the calendar year
376.19 preceding the end of the members' terms. The Legislative Coordinating Commission shall
376.20 appoint one of the two recommended applicants to the commission.

376.21 Subd. 10. **Meetings.** The commission shall meet at least four times each year.
376.22 Commission meetings are subject to chapter 13D.

376.23 Subd. 11. **Conflict of interest.** A member of the commission may not participate in or
 376.24 vote on a decision of the commission relating to an organization in which the member has
 376.25 either a direct or indirect financial interest.

376.26 Subd. 12. **Expiration.** The commission shall expire on June 15, 2024.

376.27 Sec. 3. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to
 376.28 read:

376.29 Subd. 17a. **Transfers for routine administrative operations.** (a) Unless specifically
 376.30 authorized by law, the commissioner may only transfer money from the general fund to any
 376.31 other fund for routine administrative operations and may not transfer money from the general
 376.32 fund to any other fund without approval from the commissioner of management and budget.
 377.1 If the commissioner of management and budget determines that a transfer proposed by the
 377.2 commissioner is necessary for routine administrative operations of the Department of Human
 377.3 Services, the commissioner may approve the transfer. If the commissioner of management
 377.4 and budget determines that the transfer proposed by the commissioner is not necessary for
 377.5 routine administrative operations of the Department of Human Services, the commissioner
 377.6 may not approve the transfer unless the requirements of paragraph (b) are met.

377.7 (b) If the commissioner of management and budget determines that a transfer under
 377.8 paragraph (a) is not necessary for routine administrative operations of the Department of
 377.9 Human Services, the commissioner may request approval of the transfer from the Legislative
 377.10 Advisory Commission under section 3.30. To request approval of a transfer from the
 377.11 Legislative Advisory Commission, the commissioner must submit a request that includes
 377.12 the amount of the transfer, the budget activity and fund from which money would be
 377.13 transferred and the budget activity and fund to which money would be transferred, an
 377.14 explanation of the administrative necessity of the transfer, and a statement from the
 377.15 commissioner of management and budget explaining why the transfer is not necessary for
 377.16 routine administrative operations of the Department of Human Services. The Legislative
 377.17 Advisory Commission shall review the proposed transfer and make a recommendation
 377.18 within 20 days of the request from the commissioner. If the Legislative Advisory Commission
 377.19 makes a positive recommendation or no recommendation, the commissioner may approve
 377.20 the transfer. If the Legislative Advisory Commission makes a negative recommendation or
 377.21 a request for more information, the commissioner may not approve the transfer. A
 377.22 recommendation of the Legislative Advisory Commission must be made by a majority of
 377.23 the commission and must be made at a meeting of the commission unless a written
 377.24 recommendation is signed by a majority of the commission members required to vote on

HOUSE ARTICLE 11

341.14 Sec. 6. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to
 341.15 read:

341.16 Subd. 17a. **Transfers for routine administrative operations.** (a) The commissioner
 341.17 may only transfer money from the general fund to any other fund for routine administrative
 341.18 operations and may not transfer money from the general fund to any other fund without
 341.19 approval from the commissioner of management and budget unless specifically authorized
 341.20 by law. If the commissioner of management and budget determines that a transfer proposed
 341.21 by the commissioner is necessary for routine administrative operations of the Department
 341.22 of Human Services, the commissioner may approve the transfer. If the commissioner of
 341.23 management and budget determines that the transfer proposed by the commissioner is not
 341.24 necessary for routine administrative operations of the Department of Human Services, the
 341.25 commissioner may not approve the transfer unless the requirements of paragraph (b) are
 341.26 met.

341.27 (b) If the commissioner of management and budget determines that a transfer under
 341.28 paragraph (a) is not necessary for routine administrative operations of the Department of
 341.29 Human Services, the commissioner may request approval of the transfer from the Legislative
 341.30 Advisory Commission under section 3.30. To request approval of a transfer from the
 341.31 Legislative Advisory Commission, the commissioner must submit a request that includes
 341.32 the amount of the transfer, the budget activity and fund from which money would be
 341.33 transferred and the budget activity and fund to which money would be transferred, an
 342.1 explanation of the administrative necessity of the transfer, and a statement from the
 342.2 commissioner of management and budget explaining why the transfer is not necessary for
 342.3 routine administrative operations of the Department of Human Services. The Legislative
 342.4 Advisory Commission shall review the proposed transfer and make a recommendation
 342.5 within 20 days of the request from the commissioner. If the Legislative Advisory Commission
 342.6 makes a positive recommendation or no recommendation, the commissioner may approve
 342.7 the transfer. If the Legislative Advisory Commission makes a negative recommendation or
 342.8 a request for more information, the commissioner may not approve the transfer. A
 342.9 recommendation of the Legislative Advisory Commission must be made by a majority of
 342.10 the commission and must be made at a meeting of the commission unless a written
 342.11 recommendation is signed by a majority of the commission members required to vote on

377.25 the question. If the commission makes a negative recommendation or a request for more
 377.26 information, the commission may withdraw or change its recommendation.

342.12 the question. If the commission makes a negative recommendation or a request for more
 342.13 information, the commission may subsequently withdraw or change its recommendation.

HOUSE ARTICLE 2

81.3 Sec. 5. **[256.0113] ELIGIBILITY VERIFICATION.**

81.4 Subdivision 1. **Verification required; vendor contract.** (a) The commissioner shall
 81.5 ensure that medical assistance, MinnesotaCare, and Supplemental Nutrition Assistance
 81.6 Program (SNAP) eligibility determinations through the MNsure information technology
 81.7 system and through other agency eligibility determination systems include the computerized
 81.8 verification of income, residency, identity, and when applicable, assets and compliance with
 81.9 SNAP work requirements.

81.10 (b) The commissioner shall contract with a vendor to verify the eligibility of all persons
 81.11 enrolled in medical assistance, MinnesotaCare, and SNAP during a specified audit period.
 81.12 This contract shall be exempt from sections 16C.08, subdivision 2, clause (1); 16C.09,
 81.13 paragraph (a), clause (1); 43A.047, paragraph (a), and any other law to the contrary.

81.14 (c) The contract must require the vendor to comply with enrollee data privacy
 81.15 requirements and to use encryption to safeguard enrollee identity. The contract must also
 81.16 provide penalties for vendor noncompliance.

81.17 (d) The contract must include a revenue sharing agreement, under which vendor
 81.18 compensation is limited to a portion of any savings to the state resulting from the vendor's
 81.19 implementation of eligibility verification initiatives under this section.

81.20 (e) The commissioner shall use existing resources to fund any agency administrative
 81.21 and technology-related costs incurred as a result of implementing this section.

81.22 (f) All state savings resulting from implementation of the vendor contract under this
 81.23 section, minus any payments to the vendor made under the terms of the revenue sharing
 81.24 agreement, shall be deposited into the health care access fund.

81.25 Subd. 2. **Verification process; vendor duties.** (a) The verification process implemented
 81.26 by the vendor must include but is not limited to data matches of the name, date of birth,
 81.27 address, and Social Security number of each medical assistance, MinnesotaCare, and SNAP
 81.28 enrollee against relevant information in federal and state data sources, including the federal
 81.29 data hub established under the Affordable Care Act. In designing the verification process,
 81.30 the vendor, to the extent feasible, shall incorporate procedures that are compatible and

- 81.31 coordinated with, and build upon or improve, existing procedures used by the MNsure
 81.32 information technology system and other agency eligibility determination systems.
- 82.1 (b) The vendor, upon preliminary determination that an enrollee is eligible or ineligible,
 82.2 shall notify the commissioner. Within 20 business days of notification, the commissioner
 82.3 shall accept the preliminary determination or reject the preliminary determination with a
 82.4 stated reason. The commissioner shall retain final authority over eligibility determinations.
 82.5 The vendor shall keep a record of all preliminary determinations of ineligibility submitted
 82.6 to the commissioner.
- 82.7 (c) The vendor shall recommend to the commissioner an eligibility verification process
 82.8 that allows ongoing verification of enrollee eligibility under the MNsure information
 82.9 technology system and other agency eligibility determination systems.
- 82.10 (d) The commissioner and the vendor, following the conclusion of the initial contract
 82.11 period, shall jointly submit an eligibility verification audit report to the chairs and ranking
 82.12 minority members of the legislative committees with jurisdiction over health and human
 82.13 services policy and finance. The report shall include but is not limited to information in the
 82.14 form of unidentified summary data on preliminary determinations of eligibility or ineligibility
 82.15 communicated by the vendor, the actions taken on those preliminary determinations by the
 82.16 commissioner, and the commissioner's reasons for rejecting preliminary determinations by
 82.17 the vendor. The report must also include the recommendations for ongoing verification of
 82.18 enrollee eligibility required under paragraph (c).
- 82.19 (e) An eligibility verification vendor contract shall be awarded for an initial one-year
 82.20 period, beginning January 1, 2019. The commissioner shall renew the contract for up to
 82.21 three additional one-year periods and require additional eligibility verification audits, if the
 82.22 commissioner or the legislative auditor determines that the MNsure information technology
 82.23 system and other agency eligibility determination systems cannot effectively verify the
 82.24 eligibility of medical assistance, MinnesotaCare, and SNAP enrollees.
- 82.25 Sec. 6. Minnesota Statutes 2016, section 256.014, subdivision 2, is amended to read:
- 82.26 Subd. 2. **State systems account created.** (a) A state systems account is created in the
 82.27 state treasury. Money collected by the commissioner of human services for the programs
 82.28 in subdivision 1 must be deposited in the account. Money in the state systems account and
 82.29 federal matching money is appropriated to the commissioner of human services for purposes
 82.30 of this section. Any unexpended balance in the appropriations for information systems
 82.31 projects for MAXIS, PRISM, MMIS, ISDS, METS, or SSIS does not cancel and is available
 82.32 for ongoing development and operations, subject to review by the Legislative Advisory
 82.33 Commission under paragraphs (b) and (c).

83.1 (b) No unexpended balance under paragraph (a) may be expended by the commissioner
 83.2 of human services until the commissioner of management and budget has submitted the
 83.3 proposed expenditure to the members of the Legislative Advisory Commission for review
 83.4 and recommendation. If the commission makes a positive recommendation or no
 83.5 recommendation, or if the commission has not reviewed the request within 20 days after
 83.6 the date the proposed expenditure was submitted, the commissioner of management and
 83.7 budget may approve the proposed expenditure. If the commission recommends further
 83.8 review of the proposed expenditure, the commissioner shall provide additional information
 83.9 to the commission. If the commission makes a negative recommendation on the proposed
 83.10 expenditure within ten days of receiving further information, the commissioner shall not
 83.11 approve the proposed expenditure. If the commission makes a positive recommendation or
 83.12 no recommendation within ten days of receiving further information, the commissioner may
 83.13 approve the proposed expenditure.

83.14 (c) A recommendation of the commission must be made at a meeting of the commission
 83.15 unless a written recommendation is signed by all members entitled to vote on the item as
 83.16 specified in section 3.30, subdivision 2. A recommendation of the commission must be
 83.17 made by a majority of the commission.

377.27 Sec. 4. Minnesota Statutes 2016, section 256B.04, subdivision 14, is amended to read:

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

377.32 (1) eyeglasses;

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

378.4 (3) hearing aids and supplies; and

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

378.6 (i) hospital beds;

378.7 (ii) commodes;

378.8 (iii) glide-about chairs;

- 378.9 (iv) patient lift apparatus;
- 378.10 (v) wheelchairs and accessories;
- 378.11 (vi) oxygen administration equipment;
- 378.12 (vii) respiratory therapy equipment;
- 378.13 (viii) electronic diagnostic, therapeutic and life-support systems;
- 378.14 (5) nonemergency medical transportation level of need determinations, disbursement of
- 378.15 public transportation passes and tokens, and volunteer and recipient mileage and parking
- 378.16 reimbursements; and
- 378.17 (6) drugs.
- 378.18 (b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not
- 378.19 affect contract payments under this subdivision unless specifically identified.
- 378.20 (c) The commissioner may not utilize volume purchase through competitive bidding
- 378.21 and negotiation for special transportation services under the provisions of chapter 16C for
- 378.22 special transportation services or incontinence products and related supplies.
- 378.23 Sec. 5. Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 3b, is
- 378.24 amended to read:
- 378.25 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary
- 378.26 services and consultations delivered by a licensed health care provider via telemedicine in
- 378.27 the same manner as if the service or consultation was delivered in person. Coverage is
- 378.28 limited to three telemedicine services per enrollee per calendar week, except as provided
- 378.29 in paragraph (f). Telemedicine services shall be paid at the full allowable rate.
- 379.1 (b) The commissioner shall establish criteria that a health care provider must attest to
- 379.2 in order to demonstrate the safety or efficacy of delivering a particular service via
- 379.3 telemedicine. The attestation may include that the health care provider:
- 379.4 (1) has identified the categories or types of services the health care provider will provide
- 379.5 via telemedicine;
- 379.6 (2) has written policies and procedures specific to telemedicine services that are regularly
- 379.7 reviewed and updated;

- 83.18 Sec. 7. Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 3b, is
- 83.19 amended to read:

- 83.20 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary
- 83.21 services and consultations delivered by a licensed health care provider via telemedicine in
- 83.22 the same manner as if the service or consultation was delivered in person. Coverage is
- 83.23 limited to three telemedicine services per enrollee per calendar week, except as provided
- 83.24 in paragraph (f). Telemedicine services shall be paid at the full allowable rate.

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

- 83.28 (1) has identified the categories or types of services the health care provider will provide
- 83.29 via telemedicine;

- 83.30 (2) has written policies and procedures specific to telemedicine services that are regularly
- 83.31 reviewed and updated;

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

379.10 (4) has established protocols addressing how and when to discontinue telemedicine
 379.11 services; and

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

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

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

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

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

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

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

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

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

379.30 (d) For purposes of this subdivision, unless otherwise covered under this chapter,
 379.31 "telemedicine" is defined as the delivery of health care services or consultations while the
 380.1 patient is at an originating site and the licensed health care provider is at a distant site. A
 380.2 communication between licensed health care providers, or a licensed health care provider
 380.3 and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission
 380.4 does not constitute telemedicine consultations or services. Telemedicine may be provided
 380.5 by means of real-time two-way, interactive audio and visual communications, including the
 380.6 application of secure video conferencing or store-and-forward technology to provide or

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

84.1 (4) has established protocols addressing how and when to discontinue telemedicine
 84.2 services; and

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

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

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

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

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

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

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

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

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

84.21 (d) For purposes of this subdivision, unless otherwise covered under this chapter,
 84.22 "telemedicine" is defined as the delivery of health care services or consultations while the
 84.23 patient is at an originating site and the licensed health care provider is at a distant site. A
 84.24 communication between licensed health care providers, or a licensed health care provider
 84.25 and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission
 84.26 does not constitute telemedicine consultations or services. Telemedicine may be provided
 84.27 by means of real-time two-way, interactive audio and visual communications, including the
 84.28 application of secure video conferencing or store-and-forward technology to provide or

380.7 support health care delivery, which facilitate the assessment, diagnosis, consultation,
380.8 treatment, education, and care management of a patient's health care.

380.9 (e) For purposes of this section, "licensed health care provider" means a licensed health
380.10 care provider under section 62A.671, subdivision 6, ~~and~~; a community paramedic as defined
380.11 under section 144E.001, subdivision 5f; ~~or~~ a mental health practitioner defined under section
380.12 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision
380.13 of a mental health professional; "health care provider" is defined under section 62A.671,
380.14 subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

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

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

380.19 (2) the services are provided in a manner consistent with the recommendations and best
380.20 practices specified by the Centers for Disease Control and Prevention.

380.21 Sec. 6. Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 17, is
380.22 amended to read:

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

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

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

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

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

84.29 support health care delivery, which facilitate the assessment, diagnosis, consultation,
84.30 treatment, education, and care management of a patient's health care.

84.31 (e) For purposes of this section, "licensed health care provider" means a licensed health
84.32 care provider under section 62A.671, subdivision 6, a community paramedic as defined
85.1 under section 144E.001, subdivision 5f, ~~and~~ a mental health practitioner defined under
85.2 section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general
85.3 supervision of a mental health professional; "health care provider" is defined under section
85.4 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision
85.5 7.

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

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

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

- 381.3 (4) public transit, as defined in section 174.22, subdivision 7; or
- 381.4 (5) not-for-hire vehicles, including volunteer drivers.
- 381.5 (c) Medical assistance covers nonemergency medical transportation provided by
381.6 nonemergency medical transportation providers enrolled in the Minnesota health care
381.7 programs. All nonemergency medical transportation providers must comply with the
381.8 operating standards for special transportation service as defined in sections 174.29 to 174.30
381.9 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota Department of
381.10 Transportation. All drivers providing nonemergency medical transportation must be
381.11 individually enrolled with the commissioner if the driver is a subcontractor for or employed
381.12 by a provider that both has a base of operation located within a metropolitan county listed
381.13 in section 437.121, subdivision 4, and is listed in paragraph (b), clause (1) or (3). All
381.14 nonemergency medical transportation providers shall bill for nonemergency medical
381.15 transportation services in accordance with Minnesota health care programs criteria. Publicly
381.16 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
381.17 requirements outlined in this paragraph.
- 381.18 (d) An organization may be terminated, denied, or suspended from enrollment if:
- 381.19 (1) the provider has not initiated background studies on the individuals specified in
381.20 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or
- 381.21 (2) the provider has initiated background studies on the individuals specified in section
381.22 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:
- 381.23 (i) the commissioner has sent the provider a notice that the individual has been
381.24 disqualified under section 245C.14; and
- 381.25 (ii) the individual has not received a disqualification set-aside specific to the special
381.26 transportation services provider under sections 245C.22 and 245C.23.
- 381.27 (e) The administrative agency of nonemergency medical transportation must:
- 381.28 (1) adhere to the policies defined by the commissioner in consultation with the
381.29 Nonemergency Medical Transportation Advisory Committee;
- 381.30 (2) pay nonemergency medical transportation providers for services provided to
381.31 Minnesota health care programs beneficiaries to obtain covered medical services;
- 382.1 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
382.2 trips, and number of trips by mode; and

- 382.3 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a Web-based single
382.4 administrative structure assessment tool that meets the technical requirements established
382.5 by the commissioner, reconciles trip information with claims being submitted by providers,
382.6 and ensures prompt payment for nonemergency medical transportation services.
- 382.7 (f) Until the commissioner implements the single administrative structure and delivery
382.8 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
382.9 commissioner or an entity approved by the commissioner that does not dispatch rides for
382.10 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).
- 382.11 (g) The commissioner may use an order by the recipient's attending physician or a medical
382.12 or mental health professional to certify that the recipient requires nonemergency medical
382.13 transportation services. Nonemergency medical transportation providers shall perform
382.14 driver-assisted services for eligible individuals, when appropriate. Driver-assisted service
382.15 includes passenger pickup at and return to the individual's residence or place of business,
382.16 assistance with admittance of the individual to the medical facility, and assistance in
382.17 passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.
- 382.18 Nonemergency medical transportation providers must take clients to the health care
382.19 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
382.20 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
382.21 authorization from the local agency.
- 382.22 Nonemergency medical transportation providers may not bill for separate base rates for
382.23 the continuation of a trip beyond the original destination. Nonemergency medical
382.24 transportation providers must maintain trip logs, which include pickup and drop-off times,
382.25 signed by the medical provider or client, whichever is deemed most appropriate, attesting
382.26 to mileage traveled to obtain covered medical services. Clients requesting client mileage
382.27 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
382.28 services.
- 382.29 (h) The administrative agency shall use the level of service process established by the
382.30 commissioner in consultation with the Nonemergency Medical Transportation Advisory
382.31 Committee to determine the client's most appropriate mode of transportation. If public transit
382.32 or a certified transportation provider is not available to provide the appropriate service mode
382.33 for the client, the client may receive a onetime service upgrade.
- 382.34 (i) The covered modes of transportation are:
- 383.1 (1) client reimbursement, which includes client mileage reimbursement provided to
383.2 clients who have their own transportation, or to family or an acquaintance who provides
383.3 transportation to the client;

- 383.4 (2) volunteer transport, which includes transportation by volunteers using their own
383.5 vehicle;
- 383.6 (3) unassisted transport, which includes transportation provided to a client by a taxicab
383.7 or public transit. If a taxicab or public transit is not available, the client can receive
383.8 transportation from another nonemergency medical transportation provider;
- 383.9 (4) assisted transport, which includes transport provided to clients who require assistance
383.10 by a nonemergency medical transportation provider;
- 383.11 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
383.12 dependent on a device and requires a nonemergency medical transportation provider with
383.13 a vehicle containing a lift or ramp;
- 383.14 (6) protected transport, which includes transport provided to a client who has received
383.15 a prescreening that has deemed other forms of transportation inappropriate and who requires
383.16 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
383.17 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
383.18 the vehicle driver; and (ii) who is certified as a protected transport provider; and
- 383.19 (7) stretcher transport, which includes transport for a client in a prone or supine position
383.20 and requires a nonemergency medical transportation provider with a vehicle that can transport
383.21 a client in a prone or supine position.
- 383.22 (j) The local agency shall be the single administrative agency and shall administer and
383.23 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the
383.24 commissioner has developed, made available, and funded the Web-based single
383.25 administrative structure, assessment tool, and level of need assessment under subdivision
383.26 18e. The local agency's financial obligation is limited to funds provided by the state or
383.27 federal government.
- 383.28 (k) The commissioner shall:
- 383.29 (1) in consultation with the Nonemergency Medical Transportation Advisory Committee,
383.30 verify that the mode and use of nonemergency medical transportation is appropriate;
- 383.31 (2) verify that the client is going to an approved medical appointment; and
- 383.32 (3) investigate all complaints and appeals.
- 384.1 (l) The administrative agency shall pay for the services provided in this subdivision and
384.2 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,

- 384.3 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
384.4 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.
- 384.5 (m) Payments for nonemergency medical transportation must be paid based on the client's
384.6 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
384.7 medical assistance reimbursement rates for nonemergency medical transportation services
384.8 that are payable by or on behalf of the commissioner for nonemergency medical
384.9 transportation services are:
- 384.10 (1) \$0.22 per mile for client reimbursement;
- 384.11 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
384.12 transport;
- 384.13 (3) equivalent to the standard fare for unassisted transport when provided by public
384.14 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency
384.15 medical transportation provider;
- 384.16 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;
- 384.17 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;
- 384.18 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and
- 384.19 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
384.20 an additional attendant if deemed medically necessary.
- 384.21 (n) The base rate for nonemergency medical transportation services in areas defined
384.22 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
384.23 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
384.24 services in areas defined under RUCA to be rural or super rural areas is:
- 384.25 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
384.26 rate in paragraph (m), clauses (1) to (7); and
- 384.27 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
384.28 rate in paragraph (m), clauses (1) to (7).
- 384.29 (o) For purposes of reimbursement rates for nonemergency medical transportation
384.30 services under paragraphs (m) and (n), the zip code of the recipient's place of residence
384.31 shall determine whether the urban, rural, or super rural reimbursement rate applies.

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

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

385.7 **EFFECTIVE DATE.** Paragraph (c) is effective January 1, 2019.

385.8 Sec. 7. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
 385.9 to read:

385.10 Subd. 17d. **Transportation services oversight.** The commissioner shall contract with
 385.11 a vendor or dedicate staff for oversight of providers of nonemergency medical transportation
 385.12 services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules,
 385.13 parts 9505.2160 to 9505.2245.

385.14 **EFFECTIVE DATE.** This section is July 1, 2018.

385.15 Sec. 8. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
 385.16 to read:

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

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

385.27 **EFFECTIVE DATE.** This section is effective July 1, 2018.

385.28 Sec. 9. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
 385.29 to read:

385.30 Subd. 17f. **Transportation provider training.** The commissioner shall make available
 385.31 to providers of nonemergency medical transportation and all drivers training materials and

85.13 Sec. 8. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
 85.14 to read:

85.15 Subd. 17d. **Transportation services oversight.** The commissioner shall contract with
 85.16 a vendor or dedicate staff for oversight of providers of nonemergency medical transportation
 85.17 services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules,
 85.18 parts 9505.2160 to 9505.2245.

85.19 **EFFECTIVE DATE.** This section is effective July 1, 2018.

85.20 Sec. 9. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
 85.21 to read:

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

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

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

386.1 online training opportunities regarding documentation requirements, documentation
 386.2 procedures, and penalties for failing to meet documentation requirements.

86.1 Sec. 10. Minnesota Statutes 2016, section 256B.0625, subdivision 18d, is amended to
 86.2 read:

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

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

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

86.9 (ii) one county representing the rural area of the state; and

86.10 (iii) one county representing the super rural area of the state.

86.11 The Association of Minnesota Counties shall appoint one county within the 11-county
 86.12 metropolitan area and one county representing the super rural area of the state. The Minnesota
 86.13 Inter-County Association shall appoint one county within the 11-county metropolitan area
 86.14 and one county representing the rural area of the state;

86.15 (2) three voting members who represent medical assistance recipients, including persons
 86.16 with physical and developmental disabilities, persons with mental illness, seniors, children,
 86.17 and low-income individuals;

86.18 (3) ~~four~~ five voting members who represent providers that deliver nonemergency medical
 86.19 transportation services to medical assistance enrollees, one of whom is a taxicab owner or
 86.20 operator;

86.21 (4) two voting members of the house of representatives, one from the majority party and
 86.22 one from the minority party, appointed by the speaker of the house, and two voting members
 86.23 from the senate, one from the majority party and one from the minority party, appointed by
 86.24 the Subcommittee on Committees of the Committee on Rules and Administration;

86.25 (5) one voting member who represents demonstration providers as defined in section
 86.26 256B.69, subdivision 2;

- 86.27 (6) one voting member who represents an organization that contracts with state or local
86.28 governments to coordinate transportation services for medical assistance enrollees;
- 86.29 (7) one voting member who represents the Minnesota State Council on Disability;
- 86.30 (8) the commissioner of transportation or the commissioner's designee, who shall serve
86.31 as a voting member;
- 87.1 (9) one voting member appointed by the Minnesota Ambulance Association; and
- 87.2 (10) one voting member appointed by the Minnesota Hospital Association.
- 87.3 (b) Members of the advisory committee shall not be employed by the Department of
87.4 Human Services. Members of the advisory committee shall receive no compensation.
- 87.5 Sec. 11. Minnesota Statutes 2016, section 256B.0625, subdivision 30, is amended to read:
- 87.6 Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services,
87.7 federally qualified health center services, nonprofit community health clinic services, and
87.8 public health clinic services. Rural health clinic services and federally qualified health center
87.9 services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and
87.10 (C). Payment for rural health clinic and federally qualified health center services shall be
87.11 made according to applicable federal law and regulation.
- 87.12 (b) A federally qualified health center that is beginning initial operation shall submit an
87.13 estimate of budgeted costs and visits for the initial reporting period in the form and detail
87.14 required by the commissioner. A federally qualified health center that is already in operation
87.15 shall submit an initial report using actual costs and visits for the initial reporting period.
87.16 Within 90 days of the end of its reporting period, a federally qualified health center shall
87.17 submit, in the form and detail required by the commissioner, a report of its operations,
87.18 including allowable costs actually incurred for the period and the actual number of visits
87.19 for services furnished during the period, and other information required by the commissioner.
87.20 Federally qualified health centers that file Medicare cost reports shall provide the
87.21 commissioner with a copy of the most recent Medicare cost report filed with the Medicare
87.22 program intermediary for the reporting year which support the costs claimed on their cost
87.23 report to the state.
- 87.24 (c) In order to continue cost-based payment under the medical assistance program
87.25 according to paragraphs (a) and (b), a federally qualified health center or rural health clinic
87.26 must apply for designation as an essential community provider within six months of final
87.27 adoption of rules by the Department of Health according to section 62Q.19, subdivision 7.
87.28 For those federally qualified health centers and rural health clinics that have applied for

87.29 essential community provider status within the six-month time prescribed, medical assistance
 87.30 payments will continue to be made according to paragraphs (a) and (b) for the first three
 87.31 years after application. For federally qualified health centers and rural health clinics that
 87.32 either do not apply within the time specified above or who have had essential community
 87.33 provider status for three years, medical assistance payments for health services provided
 87.34 by these entities shall be according to the same rates and conditions applicable to the same
 88.1 service provided by health care providers that are not federally qualified health centers or
 88.2 rural health clinics.

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

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

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

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

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

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

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

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

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

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

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

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

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

89.6 ~~(h) Federally qualified health centers and rural health clinics shall submit claims directly~~
89.7 ~~to the commissioner for payment, and the commissioner shall provide claims information~~
89.8 ~~for recipients enrolled in a managed care plan or county-based purchasing plan to the plan~~
89.9 ~~on a regular basis as determined by the commissioner.~~

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

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

89.29 ~~**EFFECTIVE DATE.** This section is effective January 1, 2019, and applies to services~~
89.30 ~~provided on or after that date.~~

386.3 Sec. 10. Minnesota Statutes 2016, section 256B.0625, subdivision 58, is amended to read:

386.4 Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** (a) Medical
 386.5 assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT).
 386.6 The payment amount for a complete EPSDT screening shall not include charges for health
 386.7 care services and products that are available at no cost to the provider and shall not exceed
 386.8 the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

386.9 (b) A provider is not required to perform as part of an EPSDT screening any of the
 386.10 recommendations that were added on or after January 1, 2017, to the child and teen checkup
 386.11 program periodicity schedule, in order to receive the full payment amount for a complete
 386.12 EPSDT screening. This paragraph expires January 1, 2021.

386.13 (c) The commissioner shall inform the chairs and ranking minority members of the
 386.14 legislative committees with jurisdiction over health and human services of any new
 386.15 recommendations added to an EPSDT screening after January 1, 2018, that the provider is
 386.16 required to perform as part of an EPSDT screening to receive the full payment amount.

89.31 Sec. 12. **[256B.0759] DIRECT CONTRACTING PILOT PROGRAM.**

89.32 Subdivision 1. **Establishment.** The commissioner shall establish a direct contracting
 89.33 pilot program to test alternative and innovative methods of delivering care through
 90.1 community-based collaborative care networks to medical assistance and MinnesotaCare
 90.2 enrollees. The pilot program shall be designed to coordinate care delivery to enrollees who
 90.3 demonstrate a combination of medical, economic, behavioral health, cultural, and geographic
 90.4 risk factors, including persons determined to be at risk of substance abuse and opioid
 90.5 addiction. The commissioner shall issue a request for proposals to select care networks to
 90.6 deliver care through the pilot program for a three-year period beginning January 1, 2020.

90.7 Subd. 2. **Eligible individuals.** (a) The pilot program shall serve individuals who:

90.8 (1) are eligible for medical assistance under section 256B.055 or MinnesotaCare under
 90.9 chapter 256L;

90.10 (2) reside in the service area of the care network;

90.11 (3) have a combination of multiple risk factors identified by the care network and
 90.12 approved by the commissioner;

- 90.13 (4) have elected to participate in the pilot project as an alternative to receiving services
 90.14 under fee-for-service or through a managed care or county-based purchasing plan or
 90.15 integrated health partnership; and
- 90.16 (5) agree to participate in risk mitigation strategies as provided in subdivision 4, clause
 90.17 (4), if the individual is determined to be at risk of opioid addiction or substance abuse.
- 90.18 (b) The commissioner may identify individuals who are potentially eligible to be enrolled
 90.19 with a care network based on zip code or other geographic designation, utilization history,
 90.20 or other factors indicating whether an individual resides in the service area of a care network.
 90.21 The commissioner shall coordinate pilot program enrollment with the enrollment and
 90.22 procurement process for managed care and county-based purchasing plans and integrated
 90.23 health partnerships.
- 90.24 Subd. 3. Selection of care networks. Participation in the pilot program is limited to no
 90.25 more than six care networks. The commissioner shall ensure that the care networks selected
 90.26 serve different geographic areas of the state. The commissioner shall consider the following
 90.27 criteria when selecting care networks to participate in the program:
- 90.28 (1) the ability of the care network to provide or arrange for the full range of health care
 90.29 services required to be provided under section 256B.69, including but not limited to primary
 90.30 care, inpatient hospital care, specialty care, behavioral health services, and chemical
 90.31 dependency and substance abuse treatment services;
- 90.32 (2) at least 25,000 individuals reside in the service area of the care network;
- 91.1 (3) the care network serves a high percentage of patients who are enrolled in Minnesota
 91.2 health care programs or are uninsured compared to the overall Minnesota population; and
- 91.3 (4) the care network can demonstrate the capacity to improve health outcomes and reduce
 91.4 total cost of care for the population in its service area through better patient engagement,
 91.5 coordination of care, and the provision of specialized services to address risk factors related
 91.6 to opioid addiction and substance abuse, and address nonclinical risk factors and barriers
 91.7 to access.
- 91.8 Subd. 4. Requirements for participating care networks. (a) A care network selected
 91.9 to participate in the pilot program must:
- 91.10 (1) accept a capitation rate for enrollees equal to the capitation rate that would otherwise
 91.11 apply to the enrollees under section 256B.69;

- 91.12 (2) comply with all requirements in section 256B.69 related to performance targets,
 91.13 capitation rate withholds, and administrative expenses;
- 91.14 (3) maintain adequate reserves and demonstrate the ability to bear risk, based upon
 91.15 criteria established by the commissioner under the request for proposals, or demonstrate to
 91.16 the commissioner that this requirement has been met through a contract with a health plan
 91.17 company, third-party administrator, stop-loss insurer, or other entity; and
- 91.18 (4) assess all enrollees for risk factors related to opioid addiction and substance abuse
 91.19 and, based upon the professional judgment of the health care provider, require enrollees
 91.20 determined to be at risk to enter into a patient provider agreement, submit to urine drug
 91.21 screening, and participate in other risk mitigation strategies; and
- 91.22 (5) participate in quality of care and financial reporting initiatives, in the form and manner
 91.23 specified by the commissioner.
- 91.24 (b) An existing integrated health partnership that meets the criteria in this section is
 91.25 eligible to participate in the pilot program while continuing as an integrated health
 91.26 partnership.
- 91.27 **Subd. 5. Requirements for the commissioner.** (a) The commissioner shall provide all
 91.28 participating care networks with enrollee utilization and cost information similar to that
 91.29 provided by the commissioner to integrated health partnerships.
- 91.30 (b) The commissioner, in consultation with the commissioner of health and care networks,
 91.31 shall design and administer the pilot program in a manner that allows the testing of new
 91.32 care coordination models and quality-of-care measures to determine the extent to which the
 92.1 care delivered by the pilot program, relative to the care delivered under fee-for-service and
 92.2 by managed care and county-based purchasing plans and integrated health partnerships:
- 92.3 (1) improves outcomes and reduces the total cost of care for the population served; and
- 92.4 (2) reduces administrative burdens and costs for health care providers and state agencies.
- 92.5 (c) The commissioner, based on the analysis under paragraph (b), shall evaluate the pilot
 92.6 program and present recommendations as to whether the pilot program should be continued
 92.7 or expanded to the chairs and ranking minority members of the legislative committees with
 92.8 jurisdiction over health and human services policy and finance by February 15, 2022.
- 92.9 **Sec. 13. Minnesota Statutes 2016, section 256B.69, subdivision 5a, is amended to read:**

92.10 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and
92.11 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner
92.12 may issue separate contracts with requirements specific to services to medical assistance
92.13 recipients age 65 and older.

92.14 (b) A prepaid health plan providing covered health services for eligible persons pursuant
92.15 to chapters 256B and 256L is responsible for complying with the terms of its contract with
92.16 the commissioner. Requirements applicable to managed care programs under chapters 256B
92.17 and 256L established after the effective date of a contract with the commissioner take effect
92.18 when the contract is next issued or renewed.

92.19 (c) The commissioner shall withhold five percent of managed care plan payments under
92.20 this section and county-based purchasing plan payments under section 256B.692 for the
92.21 prepaid medical assistance program pending completion of performance targets. Each
92.22 performance target must be quantifiable, objective, measurable, and reasonably attainable,
92.23 except in the case of a performance target based on a federal or state law or rule. Criteria
92.24 for assessment of each performance target must be outlined in writing prior to the contract
92.25 effective date. Clinical or utilization performance targets and their related criteria must
92.26 consider evidence-based research and reasonable interventions when available or applicable
92.27 to the populations served, and must be developed with input from external clinical experts
92.28 and stakeholders, including managed care plans, county-based purchasing plans, and
92.29 providers. The managed care or county-based purchasing plan must demonstrate, to the
92.30 commissioner's satisfaction, that the data submitted regarding attainment of the performance
92.31 target is accurate. The commissioner shall periodically change the administrative measures
92.32 used as performance targets in order to improve plan performance across a broader range
92.33 of administrative services. The performance targets must include measurement of plan
93.1 efforts to contain spending on health care services and administrative activities. The
93.2 commissioner may adopt plan-specific performance targets that take into account factors
93.3 affecting only one plan, including characteristics of the plan's enrollee population. The
93.4 withheld funds must be returned no sooner than July of the following year if performance
93.5 targets in the contract are achieved. The commissioner may exclude special demonstration
93.6 projects under subdivision 23.

93.7 (d) The commissioner shall require that managed care plans use the assessment and
93.8 authorization processes, forms, timelines, standards, documentation, and data reporting
93.9 requirements, protocols, billing processes, and policies consistent with medical assistance
93.10 fee-for-service or the Department of Human Services contract requirements consistent with
93.11 medical assistance fee-for-service or the Department of Human Services contract
93.12 requirements for all personal care assistance services under section 256B.0659.

93.13 (e) Effective for services rendered on or after January 1, 2012, the commissioner shall
93.14 include as part of the performance targets described in paragraph (c) a reduction in the health
93.15 plan's emergency department utilization rate for medical assistance and MinnesotaCare

93.16 enrollees, as determined by the commissioner. For 2012, the reduction shall be based on
93.17 the health plan's utilization in 2009. To earn the return of the withhold each subsequent
93.18 year, the managed care plan or county-based purchasing plan must achieve a qualifying
93.19 reduction of no less than ten percent of the plan's emergency department utilization rate for
93.20 medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described
93.21 in subdivisions 23 and 28, compared to the previous measurement year until the final
93.22 performance target is reached. When measuring performance, the commissioner must
93.23 consider the difference in health risk in a managed care or county-based purchasing plan's
93.24 membership in the baseline year compared to the measurement year, and work with the
93.25 managed care or county-based purchasing plan to account for differences that they agree
93.26 are significant.

93.27 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
93.28 the following calendar year if the managed care plan or county-based purchasing plan
93.29 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate
93.30 was achieved. The commissioner shall structure the withhold so that the commissioner
93.31 returns a portion of the withheld funds in amounts commensurate with achieved reductions
93.32 in utilization less than the targeted amount.

93.33 The withhold described in this paragraph shall continue for each consecutive contract
93.34 period until the plan's emergency room utilization rate for state health care program enrollees
93.35 is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance
94.1 and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the
94.2 health plans in meeting this performance target and shall accept payment withholds that
94.3 may be returned to the hospitals if the performance target is achieved.

94.4 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall
94.5 include as part of the performance targets described in paragraph (c) a reduction in the plan's
94.6 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as
94.7 determined by the commissioner. To earn the return of the withhold each year, the managed
94.8 care plan or county-based purchasing plan must achieve a qualifying reduction of no less
94.9 than five percent of the plan's hospital admission rate for medical assistance and
94.10 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
94.11 28, compared to the previous calendar year until the final performance target is reached.
94.12 When measuring performance, the commissioner must consider the difference in health risk
94.13 in a managed care or county-based purchasing plan's membership in the baseline year
94.14 compared to the measurement year, and work with the managed care or county-based
94.15 purchasing plan to account for differences that they agree are significant.

94.16 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
94.17 the following calendar year if the managed care plan or county-based purchasing plan
94.18 demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization
94.19 rate was achieved. The commissioner shall structure the withhold so that the commissioner

94.20 returns a portion of the withheld funds in amounts commensurate with achieved reductions
94.21 in utilization less than the targeted amount.

94.22 The withhold described in this paragraph shall continue until there is a 25 percent
94.23 reduction in the hospital admission rate compared to the hospital admission rates in calendar
94.24 year 2011, as determined by the commissioner. The hospital admissions in this performance
94.25 target do not include the admissions applicable to the subsequent hospital admission
94.26 performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting
94.27 this performance target and shall accept payment withholds that may be returned to the
94.28 hospitals if the performance target is achieved.

94.29 (g) Effective for services rendered on or after January 1, 2012, the commissioner shall
94.30 include as part of the performance targets described in paragraph (c) a reduction in the plan's
94.31 hospitalization admission rates for subsequent hospitalizations within 30 days of a previous
94.32 hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare
94.33 enrollees, as determined by the commissioner. To earn the return of the withhold each year,
94.34 the managed care plan or county-based purchasing plan must achieve a qualifying reduction
94.35 of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees,
95.1 excluding enrollees in programs described in subdivisions 23 and 28, of no less than five
95.2 percent compared to the previous calendar year until the final performance target is reached.

95.3 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
95.4 the following calendar year if the managed care plan or county-based purchasing plan
95.5 demonstrates to the satisfaction of the commissioner that a qualifying reduction in the
95.6 subsequent hospitalization rate was achieved. The commissioner shall structure the withhold
95.7 so that the commissioner returns a portion of the withheld funds in amounts commensurate
95.8 with achieved reductions in utilization less than the targeted amount.

95.9 The withhold described in this paragraph must continue for each consecutive contract
95.10 period until the plan's subsequent hospitalization rate for medical assistance and
95.11 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
95.12 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year
95.13 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall
95.14 accept payment withholds that must be returned to the hospitals if the performance target
95.15 is achieved.

95.16 (h) Effective for services rendered on or after January 1, 2013, through December 31,
95.17 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
95.18 this section and county-based purchasing plan payments under section 256B.692 for the
95.19 prepaid medical assistance program. The withheld funds must be returned no sooner than
95.20 July 1 and no later than July 31 of the following year. The commissioner may exclude
95.21 special demonstration projects under subdivision 23.

95.22 (i) Effective for services rendered on or after January 1, 2014, the commissioner shall
95.23 withhold three percent of managed care plan payments under this section and county-based
95.24 purchasing plan payments under section 256B.692 for the prepaid medical assistance
95.25 program. The withheld funds must be returned no sooner than July 1 and no later than July
95.26 31 of the following year. The commissioner may exclude special demonstration projects
95.27 under subdivision 23.

95.28 (j) A managed care plan or a county-based purchasing plan under section 256B.692 may
95.29 include as admitted assets under section 62D.044 any amount withheld under this section
95.30 that is reasonably expected to be returned.

95.31 (k) Contracts between the commissioner and a prepaid health plan are exempt from the
95.32 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
95.33 7.

96.1 (l) The return of the withhold under paragraphs (h) and (i) is not subject to the
96.2 requirements of paragraph (c).

96.3 (m) Managed care plans and county-based purchasing plans shall maintain current and
96.4 fully executed agreements for all subcontractors, including bargaining groups, for
96.5 administrative services that are expensed to the state's public health care programs.
96.6 Subcontractor agreements determined to be material, as defined by the commissioner after
96.7 taking into account state contracting and relevant statutory requirements, must be in the
96.8 form of a written instrument or electronic document containing the elements of offer,
96.9 acceptance, consideration, payment terms, scope, duration of the contract, and how the
96.10 subcontractor services relate to state public health care programs. Upon request, the
96.11 commissioner shall have access to all subcontractor documentation under this paragraph.
96.12 Nothing in this paragraph shall allow release of information that is nonpublic data pursuant
96.13 to section 13.02.

96.14 (n) Effective for services provided on or after January 1, 2019, through December 31,
96.15 2019, the commissioner shall withhold two percent of the capitation payment provided to
96.16 managed care plans under this section, and county-based purchasing plans under section
96.17 256B.692, for each medical assistance enrollee. The withheld funds must be returned no
96.18 sooner than July 1 and no later than July 31 of the following year, for capitation payments
96.19 for enrollees for whom the plan has submitted to the commissioner a verification of coverage
96.20 form completed and signed by the enrollee. The verification of coverage form must be
96.21 developed by the commissioner and made available to managed care and county-based
96.22 purchasing plans. The form must require the enrollee to provide the enrollee's name and
96.23 street address and the name of the managed care or county-based purchasing plan selected
96.24 by or assigned to the enrollee and must include a signature block that allows the enrollee
96.25 to attest that the information provided is accurate. A plan shall request that all enrollees
96.26 complete the verification of coverage form and shall submit all completed forms to the

96.27 commissioner by February 28, 2019. If a completed form for an enrollee is not received by
 96.28 the commissioner by that date:

96.29 (1) the commissioner shall not return to the plan funds withheld for that enrollee;

96.30 (2) the commissioner shall cease making capitation payments to the plan for that enrollee,
 96.31 effective with the April 2019 coverage month; and

96.32 (3) the commissioner shall disenroll the enrollee from medical assistance, subject to any
 96.33 enrollee appeal.

97.1 (o) The commissioner may establish and administer a single preferred drug list for
 97.2 medical assistance and MinnesotaCare enrollees receiving services through fee-for-service,
 97.3 integrated health partnerships, managed care, or county-based purchasing, only if the
 97.4 commissioner first studies this change and then obtains legislative approval in the form of
 97.5 enacted legislation authorizing the change. In conducting the study, the commissioner shall
 97.6 consult with interested and affected stakeholders including but not limited to managed care
 97.7 organizations, county-based purchasers, integrated health partnerships, health care providers,
 97.8 and enrollees. The commissioner shall report to the chairs and ranking minority members
 97.9 of the legislative committees with jurisdiction over health and human services policy and
 97.10 finance on the anticipated impact of the proposed change on: the state budget, access to
 97.11 services, quality of both outcomes and enrollee experience, and administrative efficiency.
 97.12 The report must also include an assessment of possible unintended consequences of the use
 97.13 of a single preferred drug list.

386.17 Sec. 11. **[256B.758] REIMBURSEMENT FOR DOULA SERVICES.**

386.18 Effective for services provided on or after July 1, 2018, payments for doula services
 386.19 provided by a certified doula shall be \$47 per prenatal or postpartum visit, up to a total of
 386.20 six visits; and \$488 for attending and providing doula services at a birth.

386.21 Sec. 12. Laws 2017, First Special Session chapter 6, article 4, section 61, is amended to
 386.22 read:

386.23 Sec. 61. **CAPITATION PAYMENT DELAY.**

386.24 (a) The commissioner of human services shall delay the medical assistance capitation
 386.25 payment to managed care plans and county-based purchasing plans due in May 2019 until
 386.26 July 1, 2019. The payment shall be made no earlier than July 1, 2019, and no later than July
 386.27 31, 2019.

386.28 (b) The commissioner of human services shall delay the medical assistance capitation
 386.29 payment to managed care plans and county-based purchasing plans due in May 2021 until

386.30 July 1, 2021. The payment shall be made no earlier than July 1, 2021, and no later than July
387.1 31, 2021. This paragraph does not apply to the capitation payment for adults without
387.2 dependent children.

387.3 Sec. 13. **DIRECTION TO COMMISSIONER.**

387.4 By August 1, 2020, the commissioner of human services shall issue a report to the chairs
387.5 and ranking minority members of the house of representatives and senate committees with
387.6 jurisdiction over health and human services. The commissioner must include in the report
387.7 the commissioner's findings regarding the impact of driver enrollment under Minnesota
387.8 Statutes, section 256B.0625, subdivision 17, paragraph (c), on the program integrity of the
387.9 nonemergency medical transportation program. The commissioner must include a
387.10 recommendation, based on the findings in the report, regarding expanding the driver
387.11 enrollment requirement.

387.12 Sec. 14. **MINNESOTA HEALTH POLICY COMMISSION; FIRST**
387.13 **APPOINTMENTS; FIRST MEETING.**

387.14 The Health Policy Commission Advisory Council shall make its recommendations under
387.15 Minnesota Statutes, section 62J.90, subdivision 9, for candidates to serve on the Minnesota
387.16 Health Policy Commission to the Legislative Coordinating Commission by September 30,
387.17 2018. The Legislative Coordinating Commission shall make the first appointments of public
387.18 members to the Minnesota Health Policy Commission under Minnesota Statutes, section
387.19 62J.90, by January 15, 2019. The Legislative Coordinating Commission shall designate five
387.20 members to serve terms that are coterminous with the governor and six members to serve
387.21 terms that end on the first Monday in January one year after the terms of the other members
387.22 conclude. The director of the Legislative Coordinating Commission shall convene the first
387.23 meeting of the Minnesota Health Policy Commission by June 15, 2019, and shall act as the
387.24 chair until the commission elects a chair at its first meeting.

387.25 Sec. 15. **PAIN MANAGEMENT.**

387.26 (a) The Health Services Policy Committee established under Minnesota Statutes, section
387.27 256B.0625, subdivision 3c, shall evaluate and make recommendations on the integration
387.28 of nonpharmacologic pain management that are clinically viable and sustainable; reduce or
387.29 eliminate chronic pain conditions; improve functional status; and prevent addiction and
387.30 reduce dependence on opiates or other pain medications. The recommendations must be
387.31 based on best practices for the effective treatment of musculoskeletal pain provided by
387.32 health practitioners identified in paragraph (b), and covered under medical assistance. Each
387.33 health practitioner represented under paragraph (b) shall present the minimum best integrated
388.1 practice recommendations, policies, and scientific evidence for nonpharmacologic treatment
388.2 options for eliminating pain and improving functional status within their full professional

388.3 scope. Recommendations for integration of services may include guidance regarding
 388.4 screening for co-occurring behavioral health diagnoses; protocols for communication between
 388.5 all providers treating a unique individual, including protocols for follow-up; and universal
 388.6 mechanisms to assess improvements in functional status.

388.7 (b) In evaluating and making recommendations, the Health Services Policy Committee
 388.8 shall consult and collaborate with the following health practitioners: acupuncture practitioners
 388.9 licensed under Minnesota Statutes, chapter 147B; chiropractors licensed under Minnesota
 388.10 Statutes, sections 148.01 to 148.10; physical therapists licensed under Minnesota Statutes,
 388.11 sections 148.68 to 148.78; medical and osteopathic physicians licensed under Minnesota
 388.12 Statutes, chapter 147, and advanced practice registered nurses licensed under Minnesota
 388.13 Statutes, sections 148.171 to 148.285, with experience in providing primary care
 388.14 collaboratively within a multidisciplinary team of health care practitioners who employ
 388.15 nonpharmacologic pain therapies; and psychologists licensed under Minnesota Statutes,
 388.16 section 148.907.

388.17 (c) The commissioner shall submit a progress report to the chairs and ranking minority
 388.18 members of the legislative committees with jurisdiction over health and human services
 388.19 policy and finance by January 15, 2019, and shall report final recommendations by August
 388.20 1, 2019. The final report may also contain recommendations for developing and implementing
 388.21 a pilot program to assess the clinical viability, sustainability, and effectiveness of integrated
 388.22 nonpharmacologic, multidisciplinary treatments for managing musculoskeletal pain and
 388.23 improving functional status.

97.14 Sec. 14. **ENCOUNTER REPORTING OF 340B ELIGIBLE DRUGS.**

97.15 (a) The commissioner of human services, in consultation with federally qualified health
 97.16 centers, managed care organizations, and contract pharmacies, shall develop
 97.17 recommendations for a process to identify and report at point of sale the 340B drugs that
 97.18 are dispensed to enrollees of managed care organizations who are patients of a federally
 97.19 qualified health center, and to exclude these claims from the Medicaid Drug Rebate Program
 97.20 and ensure that duplicate discounts for drugs do not occur. In developing this process, the
 97.21 commissioner shall assess the impact of allowing federally qualified health centers to utilize
 97.22 the 340B Drug Pricing Program drug discounts if a federally qualified health center utilizes
 97.23 a contract pharmacy for a patient enrolled in the prepaid medical assistance program.

97.24 (b) By March 1, 2019, the commissioner shall report the recommendations to the chairs
 97.25 and ranking minority members of the house of representatives and senate committees with
 97.26 jurisdiction over medical assistance.

97.27 Sec. 15. **RECONCILIATION OF MINNESOTACARE PREMIUMS.**

97.28 Subdivision 1. **Reconciliation required.** (a) The commissioner of human services shall
 97.29 reconcile all MinnesotaCare premiums paid or due for health coverage provided during the
 97.30 period January 1, 2014, through December 31, 2017, by July 1, 2018. Based on this
 97.31 reconciliation, the commissioner shall notify each MinnesotaCare enrollee or former enrollee
 97.32 of any amount owed as premiums, refund to the enrollee or former enrollee any premium
 98.1 overpayment, and enter into a payment arrangement with the enrollee or former enrollee as
 98.2 necessary.

98.3 (b) The commissioner of human services is prohibited from using agency staff and
 98.4 resources to plan, develop, or promote any proposal that would offer a health insurance
 98.5 product on the individual market that would offer consumers similar benefits and networks
 98.6 as the standard MinnesotaCare program, until the commissioner of management and budget
 98.7 has determined under subdivision 2 that the commissioner is in compliance with the
 98.8 requirements of this section.

98.9 Subd. 2. **Determination of compliance; contingent transfer.** The commissioner of
 98.10 management and budget shall determine whether the commissioner of human services has
 98.11 complied with the requirements of subdivision 1. If the commissioner of management and
 98.12 budget determines that the commissioner of human services is not in compliance with
 98.13 subdivision 1, the commissioner of management and budget shall transfer \$10,000 from
 98.14 the central office operations account of the Department of Human Services to the premium
 98.15 security plan account established under Minnesota Statutes, section 62E.25, for each business
 98.16 day of noncompliance.

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

98.18 Sec. 16. **CONTRACT TO RECOVER THIRD-PARTY LIABILITY.**

98.19 The commissioner shall contract with a vendor to implement a third-party liability
 98.20 recovery program for medical assistance and MinnesotaCare. Under the terms of the contract,
 98.21 the vendor shall be reimbursed using a percentage of the money recovered through the
 98.22 third-party liability recovery program. All money recovered that remains after reimbursement
 98.23 of the vendor is available for operation of the medical assistance and MinnesotaCare
 98.24 programs. The use of this money must be authorized in law by the legislature.

98.25 **EFFECTIVE DATE.** This section is effective July 1, 2018.

**HOUSE ARTICLE 2, SECTIONS 17, 18, 19, AND 20 ARE LOCATED IN
 THE SENATE ARTICLE 24 SIDE BY SIDE.**

388.24 Sec. 16. **REPEALER.**

388.25 **(a) Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 31c, is repealed.**

388.26 **(b) Minnesota Statutes 2016, section 256B.0625, subdivision 18b, is repealed.**