

**SENATE  
STATE OF MINNESOTA  
NINETY-THIRD SESSION**

**S.F. No. 3020**

(SENATE AUTHORS: FATEH, Hawj, Mitchell, Mohamed and Pappas)

DATE  
03/20/2023

D-PG

Introduction and first reading  
Referred to Health and Human Services

OFFICIAL STATUS

1.1 A bill for an act  
1.2 relating to health; guaranteeing that health care is available and affordable for  
1.3 every Minnesotan; establishing the Minnesota Health Plan, Minnesota Health  
1.4 Board, Minnesota Health Fund, Office of Health Quality and Planning, ombudsman  
1.5 for patient advocacy, and auditor general for the Minnesota Health Plan; requesting  
1.6 an Affordable Care Act 1332 waiver; authorizing rulemaking; appropriating money;  
1.7 amending Minnesota Statutes 2022, sections 13.3806, by adding a subdivision;  
1.8 14.03, subdivisions 2, 3; 15A.0815, subdivision 2; proposing coding for new law  
1.9 as Minnesota Statutes, chapter 62X.

1.10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.11 **ARTICLE 1**  
1.12 **MINNESOTA HEALTH PLAN**

1.13 Section 1. **[62X.01] HEALTH PLAN REQUIREMENTS.**

1.14 In order to keep Minnesota residents healthy and provide the best quality of health care,  
1.15 the Minnesota Health Plan must:

1.16 (1) ensure all Minnesota residents are covered;

1.17 (2) cover all necessary care, including medical, dental, vision and hearing, mental health,  
1.18 chemical dependency treatment, prescription drugs, medical equipment and supplies,  
1.19 long-term care, and home care;

1.20 (3) allow patients to choose their providers;

1.21 (4) reduce costs by negotiating fair prices and by cutting administrative bureaucracy,  
1.22 not by restricting or denying care;

1.23 (5) be affordable to all through premiums based on ability to pay and elimination of  
1.24 co-pays;

- 2.1 (6) focus on preventive care and early intervention to improve health;  
 2.2 (7) ensure that there are enough health care providers to guarantee timely access to care;  
 2.3 (8) continue Minnesota's leadership in medical education, research, and technology;  
 2.4 (9) provide adequate and timely payments to providers; and  
 2.5 (10) use a simple funding and payment system.

2.6 **Sec. 2. [62X.02] MINNESOTA HEALTH PLAN GENERAL PROVISIONS.**

2.7 Subdivision 1. **Short title.** This chapter may be cited as the "Minnesota Health Plan."

2.8 Subd. 2. **Purpose.** The Minnesota Health Plan shall provide all medically necessary  
 2.9 health care services for all Minnesota residents in a manner that meets the requirements in  
 2.10 section 62X.01.

2.11 Subd. 3. **Definitions.** As used in this chapter, the following terms have the meanings  
 2.12 provided:

2.13 (a) "Board" means the Minnesota Health Board.

2.14 (b) "Plan" means the Minnesota Health Plan.

2.15 (c) "Fund" means the Minnesota Health Fund.

2.16 (d) "Medically necessary" means services or supplies needed to promote health and to  
 2.17 prevent, diagnose, or treat a particular patient's medical condition that meet accepted  
 2.18 standards of medical practice within a provider's professional peer group and geographic  
 2.19 region.

2.20 (e) "Institutional provider" means an inpatient hospital, nursing facility, rehabilitation  
 2.21 facility, and other health care facilities that provide overnight care.

2.22 (f) "Noninstitutional provider" means individual providers, group practices, clinics,  
 2.23 outpatient surgical centers, imaging centers, and other health facilities that do not provide  
 2.24 overnight care.

2.25 **ARTICLE 2**

2.26 **ELIGIBILITY**

2.27 **Section 1. [62X.03] ELIGIBILITY.**

2.28 Subdivision 1. **Residency.** All Minnesota residents are eligible for the Minnesota Health  
 2.29 Plan.

3.1 Subd. 2. **Enrollment; identification.** The Minnesota Health Board shall establish a  
3.2 procedure to enroll residents and provide each with identification that may be used by health  
3.3 care providers to confirm eligibility for services. The application for enrollment shall be no  
3.4 more than two pages.

3.5 Subd. 3. **Residents temporarily out of state.** (a) The Minnesota Health Plan shall  
3.6 provide health care coverage to Minnesota residents who are temporarily out of the state  
3.7 who intend to return and reside in Minnesota.

3.8 (b) Coverage for emergency care obtained out of state shall be at prevailing local rates.  
3.9 Coverage for nonemergency care obtained out of state, or routine care obtained out of state  
3.10 by people living in border communities, shall be according to rates and conditions established  
3.11 by the board.

3.12 Subd. 4. **Visitors.** Nonresidents visiting Minnesota shall be billed by the board for all  
3.13 services received under the Minnesota Health Plan. The board may enter into  
3.14 intergovernmental arrangements or contracts with other states and countries to provide  
3.15 reciprocal coverage for temporary visitors.

3.16 Subd. 5. **Nonresident employed in Minnesota.** The board shall extend eligibility to  
3.17 nonresidents employed in Minnesota under a premium schedule set by the board.

3.18 Subd. 6. **Business outside of Minnesota employing Minnesota residents.** The board  
3.19 shall apply for a federal waiver to collect the employer contribution mandated by federal  
3.20 law.

3.21 Subd. 7. **Retiree benefits.** All persons who are eligible for retiree medical benefits under  
3.22 an employer-employee contract shall remain eligible for those benefits.

3.23 Subd. 8. **Presumptive eligibility.** (a) An individual is presumed eligible for coverage  
3.24 under the Minnesota Health Plan if the individual arrives at a health facility unconscious,  
3.25 comatose, or otherwise unable, because of the individual's physical or mental condition, to  
3.26 document eligibility or to act on the individual's own behalf. If the patient is a minor, the  
3.27 patient is presumed eligible, and the health facility shall provide care as if the patient were  
3.28 eligible.

3.29 (b) Any individual is presumed eligible when brought to a health facility according to  
3.30 any provision of section 253B.05.

3.31 (c) Any individual involuntarily committed to an acute psychiatric facility or to a hospital  
3.32 with psychiatric beds according to any provision of section 253B.05, providing for  
3.33 involuntary commitment, is presumed eligible.

4.1 (d) All health facilities subject to state and federal provisions governing emergency  
 4.2 medical treatment must comply with those provisions.

4.3 Subd. 9. **Data.** Data collected because an individual applies for or is enrolled in the  
 4.4 Minnesota Health Plan are private data on individuals as defined in section 13.02, subdivision  
 4.5 12, but may be released to:

4.6 (1) providers for purposes of confirming enrollment and processing payments for benefits;

4.7 (2) the ombudsman for patient advocacy for purposes of performing duties under section  
 4.8 62X.12 or 62X.13; or

4.9 (3) the auditor general for purposes of performing duties under section 62X.14.

4.10 Sec. 2. Minnesota Statutes 2022, section 13.3806, is amended by adding a subdivision to  
 4.11 read:

4.12 Subd. 1d. **Minnesota Health Plan.** Data on enrollees under the Minnesota Health Plan  
 4.13 are classified under sections 62X.03, subdivision 9, and 62X.13, subdivision 6.

### 4.14 **ARTICLE 3**

### 4.15 **BENEFITS**

4.16 Section 1. **[62X.04] BENEFITS.**

4.17 Subdivision 1. **General provisions.** Any eligible individual may choose to receive  
 4.18 services under the Minnesota Health Plan from any participating provider.

4.19 Subd. 2. **Covered benefits.** Covered health care benefits in this chapter include all  
 4.20 medically necessary care subject to the limitations specified in subdivision 4. Covered health  
 4.21 care benefits for Minnesota Health Plan enrollees include:

4.22 (1) inpatient and outpatient health facility services;

4.23 (2) inpatient and outpatient professional health care provider services;

4.24 (3) diagnostic imaging, laboratory services, and other diagnostic and evaluative services;

4.25 (4) medical equipment, supplies, including prescribed dietary and nutritional therapies,  
 4.26 appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids,  
 4.27 their repair, technical support, and customization needed for individual use;

4.28 (5) inpatient and outpatient rehabilitative care;

4.29 (6) emergency care services;

- 5.1 (7) emergency transportation;
- 5.2 (8) necessary transportation for health care services for persons with disabilities or who
- 5.3 may qualify as low income;
- 5.4 (9) child and adult immunizations and preventive care;
- 5.5 (10) reproductive and sexual health care;
- 5.6 (11) health and wellness education;
- 5.7 (12) hospice care;
- 5.8 (13) care in a skilled nursing facility;
- 5.9 (14) home health care including health care provided in an assisted living facility;
- 5.10 (15) mental health services;
- 5.11 (16) substance abuse treatment;
- 5.12 (17) dental care;
- 5.13 (18) vision care;
- 5.14 (19) hearing care;
- 5.15 (20) prescription drugs and devices;
- 5.16 (21) podiatric care;
- 5.17 (22) chiropractic care;
- 5.18 (23) acupuncture;
- 5.19 (24) therapies which are shown by the National Institutes of Health National Center for
- 5.20 Complementary and Integrative Health to be safe and effective;
- 5.21 (25) blood and blood products;
- 5.22 (26) dialysis;
- 5.23 (27) adult day care;
- 5.24 (28) rehabilitative and habilitative services;
- 5.25 (29) ancillary health care or social services previously covered by Minnesota's public
- 5.26 health programs;
- 5.27 (30) case management and care coordination;

6.1 (31) language interpretation and translation for health care services, including sign  
6.2 language and Braille or other services needed for individuals with communication barriers;  
6.3 and

6.4 (32) those health care and long-term supportive services currently covered under  
6.5 Minnesota Statutes 2016, chapter 256B, for persons on medical assistance, including home  
6.6 and community-based waived services under chapter 256B.

6.7 Subd. 3. **Benefit expansion.** The Minnesota Health Board may expand health care  
6.8 benefits beyond the minimum benefits described in this section when expansion meets the  
6.9 intent of this chapter and when there are sufficient funds to cover the expansion.

6.10 Subd. 4. **Cost-sharing for the room and board portion of long-term care.** The  
6.11 Minnesota Health Board shall develop income and asset qualifications based on medical  
6.12 assistance standards for covered benefits under subdivision 2, clauses (12) and (13). All  
6.13 health care services for long-term care in a skilled nursing facility or assisted living facility  
6.14 are fully covered but, notwithstanding section 62X.20, subdivision 6, room and board costs  
6.15 may be charged to patients who do not meet income and asset qualifications.

6.16 Subd. 5. **Exclusions.** The following health care services shall be excluded from coverage  
6.17 by the Minnesota Health Plan:

6.18 (1) health care services determined to have no medical benefit by the board;

6.19 (2) treatments and procedures primarily for cosmetic purposes, unless required to correct  
6.20 a functional or congenital impairment, restore or correct a part of the body that has been  
6.21 altered as a result of injury, disease, or surgery, or determined to be medically necessary  
6.22 by a qualified, licensed health care provider in the Minnesota Health Plan; and

6.23 (3) services of a health care provider or facility that is not licensed or accredited by the  
6.24 state, except for approved services provided to a Minnesota resident who is temporarily out  
6.25 of the state.

6.26 Subd. 6. **Prohibition.** The Minnesota Health Plan shall not pay for drugs requiring a  
6.27 prescription if the pharmaceutical companies directly market those drugs to consumers in  
6.28 Minnesota.

6.29 Sec. 2. **[62X.041] PATIENT CARE.**

6.30 (a) All patients shall have a primary care provider and have access to care coordination.

7.1 (b) Referrals are not required for a patient to see a health care specialist. If a patient sees  
7.2 a specialist and does not have a primary care provider, the Minnesota Health Plan may assist  
7.3 with choosing a primary care provider.

7.4 (c) The board may establish an online registry to assist patients in identifying appropriate  
7.5 providers.

## 7.6 **ARTICLE 4**

### 7.7 **FUNDING**

#### 7.8 Section 1. **[62X.19] MINNESOTA HEALTH FUND.**

7.9 Subdivision 1. **General provisions.** (a) The Minnesota Health Fund, a revolving fund,  
7.10 is established under the jurisdiction and control of the Minnesota Health Board to implement  
7.11 the Minnesota Health Plan and to receive premiums and other sources of revenue. The fund  
7.12 shall be administered by a director appointed by the Minnesota Health Board.

7.13 (b) All money collected, received, and transferred according to this chapter shall be  
7.14 deposited in the Minnesota Health Fund.

7.15 (c) Money deposited in the Minnesota Health Fund shall be used exclusively to finance  
7.16 the Minnesota Health Plan.

7.17 (d) All claims for health care services rendered shall be made to the Minnesota Health  
7.18 Fund.

7.19 (e) All payments made for health care services shall be disbursed from the Minnesota  
7.20 Health Fund.

7.21 (f) Premiums and other revenues collected each year must be sufficient to cover that  
7.22 year's projected costs.

7.23 Subd. 2. **Accounts.** The Minnesota Health Fund shall have operating, capital, and reserve  
7.24 accounts.

7.25 Subd. 3. **Operating account.** The operating account in the Minnesota Health Fund shall  
7.26 be comprised of the accounts specified in paragraphs (a) to (e).

7.27 (a) **Medical services account.** The medical services account must be used to provide  
7.28 for all medical services and benefits covered under the Minnesota Health Plan.

7.29 (b) **Prevention account.** The prevention account must be used to establish and maintain  
7.30 primary community prevention programs, including preventive screening tests.

8.1 (c) Program administration, evaluation, planning, and assessment account. The  
8.2 program administration, evaluation, planning, and assessment account must be used to  
8.3 monitor and improve the plan's effectiveness and operations. The board may establish grant  
8.4 programs including demonstration projects for this purpose.

8.5 (d) Training and development account. The training and development account must  
8.6 be used to incentivize the training and development of health care providers and the health  
8.7 care workforce needed to meet the health care needs of the population.

8.8 (e) Health service research account. The health service research account must be used  
8.9 to support research and innovation as determined by the Minnesota Health Board, and  
8.10 recommended by the Office of Health Quality and Planning and the Ombudsman for Patient  
8.11 Advocacy.

8.12 Subd. 4. Capital account. The capital account must be used to pay for capital  
8.13 expenditures for institutional providers.

8.14 Subd. 5. Reserve account. (a) The Minnesota Health Plan must at all times hold in  
8.15 reserve an amount estimated in the aggregate to provide for the payment of all losses and  
8.16 claims for which the Minnesota Health Plan may be liable and to provide for the expense  
8.17 of adjustment or settlement of losses and claims.

8.18 (b) Money currently held in reserve by state, city, and county health programs must be  
8.19 transferred to the Minnesota Health Fund when the Minnesota Health Plan replaces those  
8.20 programs.

8.21 (c) The board shall have provisions in place to insure the Minnesota Health Plan against  
8.22 unforeseen expenditures or revenue shortfalls not covered by the reserve account. The board  
8.23 may borrow money to cover temporary shortfalls.

8.24 Subd. 6. Assets of the Minnesota Health Plan; functions of the commissioner of  
8.25 Minnesota Management and Budget. All money received by the Minnesota Health Fund  
8.26 shall be paid to the commissioner of Minnesota Management and Budget as agent of the  
8.27 board who shall not commingle these funds with any other money. The money in these  
8.28 accounts shall be paid out on warrants drawn by the commissioner on requisition by the  
8.29 board.

8.30 Subd. 7. Management. The Minnesota Health Fund shall be separate from the state  
8.31 treasury. Management of the fund shall be conducted by the Minnesota Health Board, which  
8.32 has exclusive authority over the fund.



9.1 Sec. 2. **[62X.20] REVENUE SOURCES.**

9.2 **Subdivision 1. Minnesota Health Plan premium.** (a) The Minnesota Health Board  
9.3 shall:

9.4 (1) determine the aggregate cost of providing health care according to this chapter;

9.5 (2) develop an equitable and affordable premium structure based on income, including  
9.6 unearned income, and a business health tax;

9.7 (3) in consultation with the Department of Revenue, develop an efficient means of  
9.8 collecting premiums and the business health tax; and

9.9 (4) coordinate with existing, ongoing funding sources from federal and state programs.

9.10 (b) The premium structure must be based on ability to pay.

9.11 (c) Within one year after the effective date of this act, the board shall submit to the  
9.12 governor and the legislature a report on the premium and business health tax structure  
9.13 established to finance the Minnesota Health Plan.

9.14 **Subd. 2. Federal receipts.** All federal funding received by Minnesota including the  
9.15 premium subsidies under the Affordable Care Act, Public Law 111-148, as amended by  
9.16 Public Law 111-152, is appropriated to the Minnesota Health Plan Board to be used to  
9.17 administer the Minnesota Health Plan under chapter 62X. Federal funding that is received  
9.18 for implementing and administering the Minnesota Health Plan must be used to provide  
9.19 health care for Minnesota residents.

9.20 **Subd. 3. Funds from outside sources.** Institutional providers operating under Minnesota  
9.21 Health Plan operating budgets may raise and expend funds from sources other than the  
9.22 Minnesota Health Plan including private or foundation donors. Contributions to providers  
9.23 in excess of \$500,000 must be reported to the board.

9.24 **Subd. 4. Governmental payments.** The chief executive officer and, if required under  
9.25 federal law, the commissioners of health, human services, and commerce shall seek all  
9.26 necessary waivers, exemptions, agreements, or legislation so that all current federal payments  
9.27 to the state, including the premium tax credits under the Affordable Care Act, are paid  
9.28 directly to the Minnesota Health Plan. When any required waivers, exemptions, agreements,  
9.29 or legislation are obtained, the Minnesota Health Plan shall assume responsibility for all  
9.30 health care benefits and health care services previously paid for with federal funds. In  
9.31 obtaining the waivers, exemptions, agreements, or legislation, the chief executive officer  
9.32 and, if required, commissioners shall seek from the federal government a contribution for  
9.33 health care services in Minnesota that reflects: medical inflation, the state gross domestic

10.1 product, the size and age of the population, the number of residents living below the poverty  
10.2 level, and the number of Medicare and VA eligible individuals, and that does not decrease  
10.3 in relation to the federal contribution to other states as a result of the waivers, exemptions,  
10.4 agreements, or savings from implementation of the Minnesota Health Plan.

10.5 Subd. 5. **Federal preemption.** (a) The board shall secure a repeal or a waiver of any  
10.6 provision of federal law that preempts any provision of this chapter. The commissioners of  
10.7 health, human services, and commerce shall provide all necessary assistance.

10.8 (b) In the section 1332 waiver application, the board shall request to waive any of the  
10.9 following provisions of the Patient Protection and Affordable Care Act, to the extent  
10.10 necessary to implement this act:

10.11 (1) United States Code, title 42, sections 18021 to 18024;

10.12 (2) United States Code, title 42, sections 18031 to 18033;

10.13 (3) United States Code, title 42, section 18071; and

10.14 (4) sections 36B and 5000A of the Internal Revenue Code of 1986, as amended.

10.15 (c) In the event that a repeal or a waiver of law or regulations cannot be secured, the  
10.16 board shall adopt rules, or seek conforming state legislation, consistent with federal law, in  
10.17 an effort to best fulfill the purposes of this chapter.

10.18 (d) The Minnesota Health Plan's responsibility for providing care shall be secondary to  
10.19 existing federal government programs for health care services to the extent that funding for  
10.20 these programs is not transferred to the Minnesota Health Fund or that the transfer is delayed  
10.21 beyond the date on which initial benefits are provided under the Minnesota Health Plan.

10.22 Subd. 6. **No cost-sharing.** No deductible, co-payment, coinsurance, or other cost-sharing  
10.23 shall be imposed with respect to covered benefits.

10.24 Sec. 3. **[62X.21] SUBROGATION.**

10.25 Subdivision 1. **Collateral source.** (a) Health care costs shall be collected from collateral  
10.26 sources whenever medical services provided to an individual by the MHP are, or may be,  
10.27 covered services under a policy of insurance, or other collateral source available to that  
10.28 individual, or when the individual has a right of action for compensation permitted under  
10.29 law.

10.30 (b) As used in this section, collateral source includes but is not limited to:

11.1 (1) health insurance policies and the medical components of automobile, homeowners,  
11.2 and other forms of insurance;

11.3 (2) medical components of workers' compensation;

11.4 (3) a judgment for damages for personal injury;

11.5 (4) the state of last domicile for individuals moving to Minnesota for medical care who  
11.6 have extraordinary medical needs; and

11.7 (5) any third party who is or may be liable to an individual for health care services or  
11.8 costs.

11.9 (c) An entity described in paragraph (b) is not excluded from the obligations imposed  
11.10 by this section by virtue of a contract or relationship with a government unit, agency, or  
11.11 service.

11.12 (d) The board shall negotiate waivers or make other arrangements to incorporate collateral  
11.13 sources into the Minnesota Health Plan if necessary.

11.14 Subd. 2. **Notification.** When an individual who receives health care services under the  
11.15 Minnesota Health Plan is entitled to coverage, reimbursement, indemnity, or other  
11.16 compensation from a collateral source, the individual shall notify the health care provider  
11.17 and provide information identifying the collateral source, the nature and extent of coverage  
11.18 or entitlement, and other relevant information. The health care provider shall forward this  
11.19 information to the board. The individual entitled to coverage, reimbursement, indemnity,  
11.20 or other compensation from a collateral source shall provide additional information as  
11.21 requested by the board.

11.22 Subd. 3. **Reimbursement.** (a) The Minnesota Health Plan shall seek reimbursement  
11.23 from the collateral source for services provided to the individual and may institute appropriate  
11.24 action, including legal proceedings, to recover the reimbursement. Upon demand, the  
11.25 collateral source shall pay to the Minnesota Health Fund the sums it would have paid or  
11.26 expended on behalf of the individual for the health care services provided by the Minnesota  
11.27 Health Plan.

11.28 (b) In addition to any other right to recovery provided in this section, the board shall  
11.29 have the same right to recover the reasonable value of health care benefits from a collateral  
11.30 source as provided to the commissioner of human services under section 256B.37.

11.31 Subd. 4. **Defaults, underpayments, and late payments.** (a) Default, underpayment, or  
11.32 late payment of any tax or other obligation imposed by this chapter shall result in the remedies  
11.33 and penalties provided by law, except as provided in this section.

12.1 (b) Eligibility for health care benefits under section 62X.04 shall not be impaired by any  
12.2 default, underpayment, or late payment of any premium or other obligation imposed by this  
12.3 chapter.

## 12.4 **ARTICLE 5**

### 12.5 **PAYMENTS**

#### 12.6 Section 1. **[62X.05] PROVIDER PAYMENTS.**

12.7 Subdivision 1. **General provisions.** (a) All health care providers licensed to practice in  
12.8 Minnesota may participate in the Minnesota Health Plan as well as other providers as  
12.9 determined by the board.

12.10 (b) A participating health care provider shall comply with all federal laws and regulations  
12.11 governing referral fees and fee splitting including, but not limited to, United States Code,  
12.12 title 42, sections 1320a-7b and 1395nn, whether reimbursed by federal funds or not.

12.13 (c) A fee schedule or financial incentive may not adversely affect the care a patient  
12.14 receives or the care a health provider recommends.

12.15 Subd. 2. **Payments to noninstitutional providers.** (a) The Minnesota Health Board  
12.16 shall establish and oversee a fair and efficient payment system for noninstitutional providers.

12.17 (b) The board shall pay noninstitutional providers based on rates negotiated with  
12.18 providers. Rates shall take into account the need to address provider shortages.

12.19 (c) The board shall establish payment criteria and methods of payment for care  
12.20 coordination for patients especially those with chronic illness and complex medical needs.

12.21 (d) Providers who accept any payment from the Minnesota Health Plan for a covered  
12.22 health care service shall not bill the patient for the covered health care service.

12.23 (e) Providers shall be paid within 30 business days for claims filed following procedures  
12.24 established by the board.

12.25 Subd. 3. **Payments to institutional providers.** (a) The board shall set annual budgets  
12.26 for institutional providers. These budgets shall consist of an operating and a capital budget.  
12.27 An institution's annual budget shall be set to cover its anticipated health care services for  
12.28 the next year based on past performance and projected changes in prices and health care  
12.29 service levels. The annual budget for each individual institutional provider must be set  
12.30 separately. The board shall not set a joint budget for a group of more than one institutional  
12.31 provider nor for a parent corporation that owns or operates one or more institutional provider.

13.1 (b) Providers who accept any payment from the Minnesota Health Plan for a covered  
 13.2 health care service shall not bill the patient for the covered health care service.

13.3 Subd. 4. **Capital management plan.** (a) The board shall periodically develop a capital  
 13.4 investment plan that will serve as a guide in determining the annual budgets of institutional  
 13.5 providers and in deciding whether to approve applications for approval of capital expenditures  
 13.6 by noninstitutional providers.

13.7 (b) Providers who propose to make capital purchases in excess of \$500,000 must obtain  
 13.8 board approval. The board may alter the threshold expenditure level that triggers the  
 13.9 requirement to submit information on capital expenditures. Institutional providers shall  
 13.10 propose these expenditures and submit the required information as part of the annual budget  
 13.11 they submit to the board. Noninstitutional providers shall submit applications for approval  
 13.12 of these expenditures to the board. The board must respond to capital expenditure applications  
 13.13 in a timely manner.

## 13.14 **ARTICLE 6**

### 13.15 **GOVERNANCE**

13.16 Section 1. Minnesota Statutes 2022, section 14.03, subdivision 2, is amended to read:

13.17 Subd. 2. **Contested case procedures.** The contested case procedures of the  
 13.18 Administrative Procedure Act provided in sections 14.57 to 14.69 do not apply to (a)  
 13.19 proceedings under chapter 414, except as specified in that chapter, (b) the commissioner of  
 13.20 corrections, (c) the unemployment insurance program and the Social Security disability  
 13.21 determination program in the Department of Employment and Economic Development, (d)  
 13.22 the commissioner of mediation services, (e) the Workers' Compensation Division in the  
 13.23 Department of Labor and Industry, (f) the Workers' Compensation Court of Appeals, ~~or~~ (g)  
 13.24 the Board of Pardons, or (h) the Minnesota Health Plan.

13.25 Sec. 2. Minnesota Statutes 2022, section 15A.0815, subdivision 2, is amended to read:

13.26 Subd. 2. **Group I salary limits.** The salary for a position listed in this subdivision shall  
 13.27 not exceed 133 percent of the salary of the governor. This limit must be adjusted annually  
 13.28 on January 1. The new limit must equal the limit for the prior year increased by the percentage  
 13.29 increase, if any, in the Consumer Price Index for all urban consumers from October of the  
 13.30 second prior year to October of the immediately prior year. The commissioner of management  
 13.31 and budget must publish the limit on the department's website. This subdivision applies to  
 13.32 the following positions:

- 14.1 Commissioner of administration;
- 14.2 Commissioner of agriculture;
- 14.3 Commissioner of education;
- 14.4 Commissioner of commerce;
- 14.5 Commissioner of corrections;
- 14.6 Commissioner of health;
- 14.7 Chief executive officer of the Minnesota Health Plan;
- 14.8 Commissioner, Minnesota Office of Higher Education;
- 14.9 Commissioner, Housing Finance Agency;
- 14.10 Commissioner of human rights;
- 14.11 Commissioner of human services;
- 14.12 Commissioner of labor and industry;
- 14.13 Commissioner of management and budget;
- 14.14 Commissioner of natural resources;
- 14.15 Commissioner, Pollution Control Agency;
- 14.16 Commissioner of public safety;
- 14.17 Commissioner of revenue;
- 14.18 Commissioner of employment and economic development;
- 14.19 Commissioner of transportation; and
- 14.20 Commissioner of veterans affairs.

14.21 **Sec. 3. [62X.06] MINNESOTA HEALTH BOARD.**

14.22 Subdivision 1. **Establishment.** The Minnesota Health Board is established to promote  
14.23 the delivery of high quality, coordinated health care services that enhance health; prevent  
14.24 illness, disease, and disability; slow the progression of chronic diseases; and improve personal  
14.25 health management. The board shall administer the Minnesota Health Plan. The board shall  
14.26 oversee:

- 14.27 (1) the Office of Health Quality and Planning under section 62X.09; and
- 14.28 (2) the Minnesota Health Fund under section 62X.19.

15.1 Subd. 2. **Board composition.** (a) The board shall consist of 15 members, including a  
15.2 representative selected by each of the five rural regional health planning boards under section  
15.3 62X.08 and three representatives selected by the metropolitan regional health planning  
15.4 board under section 62X.08. These members shall appoint the following additional members  
15.5 to serve on the board:

15.6 (1) one patient member and one employer member; and

15.7 (2) five providers that include one physician, one registered nurse, one mental health  
15.8 provider, one dentist, and one facility director.

15.9 (b) Each member shall qualify by taking the oath of office to uphold the Minnesota and  
15.10 United States Constitution and to operate the Minnesota Health Plan in the public interest  
15.11 by upholding the underlying principles of this chapter.

15.12 Subd. 3. **Term and compensation; selection of chair.** Board members shall serve four  
15.13 years. Board members shall set the board's compensation not to exceed the compensation  
15.14 of Public Utilities Commission members. The board shall select the chair from its  
15.15 membership.

15.16 Subd. 4. **Removal of board member.** A board member may be removed by a two-thirds  
15.17 vote of the members voting on removal. After receiving notice and hearing, a member may  
15.18 be removed for malfeasance or nonfeasance in performance of the member's duties.  
15.19 Conviction of any criminal behavior regardless of how much time has lapsed is grounds for  
15.20 immediate removal.

15.21 Subd. 5. **General duties.** The board shall:

15.22 (1) ensure that all of the requirements of section 62X.01 are met;

15.23 (2) hire a chief executive officer for the Minnesota Health Plan who shall be qualified  
15.24 after taking the oath of office specified in subdivision 2 and who shall administer all aspects  
15.25 of the plan as directed by the board;

15.26 (3) hire a director for the Office of Health Quality and Planning who shall be qualified  
15.27 after taking the oath of office specified in subdivision 2;

15.28 (4) hire a director of the Minnesota Health Fund who shall be qualified after taking the  
15.29 oath of office specified in subdivision 2;

15.30 (5) provide technical assistance to the regional boards established under section 62X.08;

16.1 (6) conduct necessary investigations and inquiries and require the submission of  
16.2 information, documents, and records the board considers necessary to carry out the purposes  
16.3 of this chapter;

16.4 (7) establish a process for the board to receive the concerns, opinions, ideas, and  
16.5 recommendations of the public regarding all aspects of the Minnesota Health Plan and the  
16.6 means of addressing those concerns;

16.7 (8) conduct other activities the board considers necessary to carry out the purposes of  
16.8 this chapter;

16.9 (9) collaborate with the agencies that license health facilities to ensure that facility  
16.10 performance is monitored and that deficient practices are recognized and corrected in a  
16.11 timely manner;

16.12 (10) adopt rules, policies, and procedures as necessary to carry out the duties assigned  
16.13 under this chapter;

16.14 (11) establish conflict of interest standards that prohibit providers from receiving any  
16.15 financial benefit from their medical decisions outside of board reimbursement, including  
16.16 any financial benefit for referring a patient for any service, product, or provider, or for  
16.17 prescribing, ordering, or recommending any drug, product, or service;

16.18 (12) establish conflict of interest standards related to pharmaceuticals, medical supplies  
16.19 and devices and their marketing to providers so that no provider receives any incentive to  
16.20 prescribe, administer, or use any product or service;

16.21 (13) require all electronic health records used by providers be fully interoperable with  
16.22 the open source electronic health records system used by the United States Veterans  
16.23 Administration;

16.24 (14) provide financial help and assistance in retraining and job placement to Minnesota  
16.25 workers who may be displaced because of the administrative efficiencies of the Minnesota  
16.26 Health Plan;

16.27 (15) ensure that assistance is provided to all workers and communities who may be  
16.28 affected by provisions in this chapter; and

16.29 (16) work with the Department of Employment and Economic Development (DEED)  
16.30 to ensure that funding and program services are promptly and efficiently distributed to all  
16.31 affected workers. DEED shall monitor and report on a regular basis on the status of displaced  
16.32 workers.



17.1 There is currently a serious shortage of providers in many health care professions, from  
17.2 medical technologists to registered nurses, and many potentially displaced health  
17.3 administrative workers already have training in some medical field. To alleviate these  
17.4 shortages, the dislocated worker support program should emphasize retraining and placement  
17.5 into health care related positions if appropriate. As Minnesota residents, all displaced workers  
17.6 shall be covered under the Minnesota Health Plan.

17.7 Subd. 6. **Waiver request duties.** Before submitting a waiver application under section  
17.8 1332 of the Patient Protection and Affordable Care Act, Public Law Number 111-148, as  
17.9 amended, the board shall do the following, as required by federal law:

17.10 (1) conduct or contract for any necessary actuarial analyses and actuarial certifications  
17.11 needed to support the board's estimates that the waiver will comply with the comprehensive  
17.12 coverage, affordability, and scope of coverage requirements in federal law;

17.13 (2) conduct or contract for any necessary economic analyses needed to support the  
17.14 board's estimates that the waiver will comply with the comprehensive coverage, affordability,  
17.15 scope of coverage, and federal deficit requirements in federal law. These analyses must  
17.16 include:

17.17 (i) a detailed ten-year budget plan; and

17.18 (ii) a detailed analysis regarding the estimated impact of the waiver on health insurance  
17.19 coverage in the state;

17.20 (3) establish a detailed draft implementation timeline for the waiver plan; and

17.21 (4) establish quarterly, annual, and cumulative targets for the comprehensive coverage,  
17.22 affordability, scope of coverage, and federal deficit requirements in federal law.

17.23 Subd. 7. **Financial duties.** The board shall:

17.24 (1) establish and after enactment into law, collect premiums and the business health tax  
17.25 according to section 62X.20, subdivision 1;

17.26 (2) approve statewide and regional budgets that include budgets for the accounts in  
17.27 section 62X.19;

17.28 (3) negotiate and establish payment rates for providers;

17.29 (4) monitor compliance with all budgets and payment rates and take action to achieve  
17.30 compliance to the extent authorized by law;

18.1 (5) pay claims for medical products or services as negotiated, and may issue requests  
18.2 for proposals from Minnesota nonprofit business corporations for a contract to process  
18.3 claims;

18.4 (6) seek federal approval to bill other states for health care coverage provided to residents  
18.5 from out-of-state who come to Minnesota for long-term care or other costly treatment when  
18.6 the resident's home state fails to provide such coverage, unless a reciprocal agreement with  
18.7 those states to provide similar coverage to Minnesota residents relocating to those states  
18.8 can be negotiated;

18.9 (7) administer the Minnesota Health Fund created under section 62X.19;

18.10 (8) annually determine the appropriate level for the Minnesota Health Plan reserve  
18.11 account and implement policies needed to establish the appropriate reserve;

18.12 (9) implement fraud prevention measures necessary to protect the operation of the  
18.13 Minnesota Health Plan; and

18.14 (10) work to ensure appropriate cost control by:

18.15 (i) instituting aggressive public health measures, early intervention and preventive care,  
18.16 health and wellness education, and promotion of personal health improvement;

18.17 (ii) making changes in the delivery of health care services and administration that improve  
18.18 efficiency and care quality;

18.19 (iii) minimizing administrative costs;

18.20 (iv) ensuring that the delivery system does not contain excess capacity; and

18.21 (v) negotiating the lowest reasonable prices for prescription drugs, medical equipment,  
18.22 and medical services.

18.23 If the board determines that there will be a revenue shortfall despite the cost control  
18.24 measures mentioned in clause (10), the board shall implement measures to correct the  
18.25 shortfall, including an increase in premiums and other revenues. The board shall report to  
18.26 the legislature on the causes of the shortfall, reasons for the inadequacy of cost controls,  
18.27 and measures taken to correct the shortfall.

18.28 Subd. 8. **Minnesota Health Board management duties.** The board shall:

18.29 (1) develop and implement enrollment procedures for the Minnesota Health Plan;

18.30 (2) implement eligibility standards for the Minnesota Health Plan;

19.1 (3) arrange for health care to be provided at convenient locations, including ensuring  
19.2 the availability of school nurses so that all students have access to health care, immunizations,  
19.3 and preventive care at public schools and encouraging providers to open small health clinics  
19.4 at larger workplaces and retail centers;

19.5 (4) make recommendations, when needed, to the legislature about changes in the  
19.6 geographic boundaries of the health planning regions;

19.7 (5) establish an electronic claims and payments system for the Minnesota Health Plan;

19.8 (6) monitor the operation of the Minnesota Health Plan through consumer surveys and  
19.9 regular data collection and evaluation activities, including evaluations of the adequacy and  
19.10 quality of services furnished under the program, the need for changes in the benefit package,  
19.11 the cost of each type of service, and the effectiveness of cost control measures under the  
19.12 program;

19.13 (7) disseminate information and establish a health care website to provide information  
19.14 to the public about the Minnesota Health Plan including providers and facilities, and state  
19.15 and regional health planning board meetings and activities;

19.16 (8) collaborate with public health agencies, schools, and community clinics;

19.17 (9) ensure that Minnesota Health Plan policies and providers, including public health  
19.18 providers, support all Minnesota residents in achieving and maintaining maximum physical  
19.19 and mental health; and

19.20 (10) annually report to the chairs and ranking minority members of the senate and house  
19.21 of representatives committees with jurisdiction over health care issues on the performance  
19.22 of the Minnesota Health Plan, fiscal condition and need for payment adjustments, any needed  
19.23 changes in geographic boundaries of the health planning regions, recommendations for  
19.24 statutory changes, receipt of revenue from all sources, whether current year goals and  
19.25 priorities are met, future goals and priorities, major new technology or prescription drugs,  
19.26 and other circumstances that may affect the cost or quality of health care.

19.27 Subd. 9. **Policy duties.** The board shall:

19.28 (1) develop and implement cost control and quality assurance procedures;

19.29 (2) ensure strong public health services including education and community prevention  
19.30 and clinical services;

19.31 (3) ensure a continuum of coordinated high-quality primary to tertiary care to all  
19.32 Minnesota residents; and

20.1 (4) implement policies to ensure that all Minnesota residents receive culturally and  
 20.2 linguistically competent care.

20.3 Subd. 10. **Self-insurance.** The board shall determine the feasibility of self-insuring  
 20.4 providers for malpractice and shall establish a self-insurance system and create a special  
 20.5 fund for payment of losses incurred if the board determines self-insuring providers would  
 20.6 reduce costs.

20.7 **Sec. 4. [62X.07] HEALTH PLANNING REGIONS.**

20.8 A metropolitan health planning region consisting of the seven-county metropolitan area  
 20.9 is established. The commissioner of health shall designate five rural health planning regions  
 20.10 from the greater Minnesota area composed of geographically contiguous counties grouped  
 20.11 on the basis of the following considerations:

20.12 (1) patterns of utilization of health care services;

20.13 (2) health care resources, including workforce resources;

20.14 (3) health needs of the population, including public health needs;

20.15 (4) geography;

20.16 (5) population and demographic characteristics; and

20.17 (6) other considerations as appropriate.

20.18 The commissioner of health shall designate the health planning regions.

20.19 **Sec. 5. [62X.08] REGIONAL HEALTH PLANNING BOARD.**

20.20 Subdivision 1. **Regional planning board composition.** (a) Each regional board shall  
 20.21 consist of one county commissioner per county selected by the county board and two county  
 20.22 commissioners per county selected by the county board in the seven-county metropolitan  
 20.23 area. A county commissioner may designate a representative to act as a member of the board  
 20.24 in the member's absence. Each board shall select the chair from among its membership.

20.25 (b) Board members shall serve for four-year terms and may receive per diems for meetings  
 20.26 as provided in section 15.059, subdivision 3.

20.27 Subd. 2. **Regional health board duties.** Regional health planning boards shall:

20.28 (1) recommend health standards, goals, priorities, and guidelines for the region;

20.29 (2) prepare an operating and capital budget for the region to recommend to the Minnesota  
 20.30 Health Board;

21.1 (3) hire a regional planning director;

21.2 (4) address the needs of high risk populations by:

21.3 (i) collaborating with community health clinics and social service providers through  
 21.4 planning and financing to provide outreach, medical care, and case management services  
 21.5 in the community for patients who, because of mental illness, homelessness, or other  
 21.6 circumstances, are unlikely to obtain needed care; and

21.7 (ii) collaborating with hospitals, medical and social service providers through planning  
 21.8 and financing to keep people healthy and reduce hospital readmissions by providing discharge  
 21.9 planning and services including medical respite and transitional care for patients leaving  
 21.10 medical facilities and mental health and chemical dependency treatment programs;

21.11 (5) collaborate with local public health care agencies to educate consumers and providers  
 21.12 on public health programs;

21.13 (6) collaborate with public health care agencies to implement public health and wellness  
 21.14 initiatives; and

21.15 (7) ensure that all parts of the region have access to a 24-hour nurse hotline and 24-hour  
 21.16 urgent care clinics.

21.17 **Sec. 6. [62X.09] OFFICE OF HEALTH QUALITY AND PLANNING.**

21.18 Subdivision 1. **Establishment.** The Minnesota Health Board shall establish an Office  
 21.19 of Health Quality and Planning to assess the quality, access, and funding adequacy of the  
 21.20 Minnesota Health Plan.

21.21 Subd. 2. **General duties.** (a) The Office of Health Quality and Planning shall make  
 21.22 annual recommendations to the board on the overall direction on subjects including:

21.23 (1) the overall effectiveness of the Minnesota Health Plan in addressing public health  
 21.24 and wellness;

21.25 (2) access to health care;

21.26 (3) quality improvement;

21.27 (4) efficiency of administration;

21.28 (5) adequacy of budget and funding;

21.29 (6) appropriateness of payments for providers;

21.30 (7) capital expenditure needs;

- 22.1 (8) long-term health care;
- 22.2 (9) mental health and substance abuse services;
- 22.3 (10) staffing levels and working conditions in health care facilities;
- 22.4 (11) identification of number and mix of health care facilities and providers required to  
22.5 best meet the needs of the Minnesota Health Plan;
- 22.6 (12) care for chronically ill patients;
- 22.7 (13) educating providers on promoting the use of advance directives with patients to  
22.8 enable patients to obtain the health care of their choice;
- 22.9 (14) research needs; and
- 22.10 (15) integration of disease management programs into health care delivery.
- 22.11 (b) Analyze shortages in health care workforce required to meet the needs of the  
22.12 population and develop plans to meet those needs in collaboration with regional planners  
22.13 and educational institutions.
- 22.14 (c) Analyze methods of paying providers and make recommendations to improve quality  
22.15 and control costs.
- 22.16 (d) Assist in coordination of the Minnesota Health Plan and public health programs.
- 22.17 **Subd. 3. Assessment and evaluation of benefits.** (a) The Office of Health Quality and  
22.18 Planning shall:
- 22.19 (1) consider health care benefit additions to the Minnesota Health Plan and evaluate  
22.20 them based on evidence of clinical efficacy;
- 22.21 (2) establish a process and criteria by which providers may request authorization to  
22.22 provide health care services and treatments that are not included in the Minnesota Health  
22.23 Plan benefit set, including experimental health care treatments;
- 22.24 (3) evaluate proposals to increase the efficiency and effectiveness of the health care  
22.25 delivery system, and make recommendations to the board based on the cost-effectiveness  
22.26 of the proposals; and
- 22.27 (4) identify complementary and alternative health care modalities that have been shown  
22.28 to be safe and effective.
- 22.29 (b) The board may convene advisory panels as needed.

23.1 **Sec. 7. [62X.10] ETHICS AND CONFLICT OF INTEREST.**

23.2 (a) All provisions of section 43A.38 apply to employees and the chief executive officer  
23.3 of the Minnesota Health Plan, the members and directors of the Minnesota Health Board,  
23.4 the regional health boards, the director of the Office of Health Quality and Planning, the  
23.5 director of the Minnesota Health Fund, and the ombudsman for patient advocacy. Failure  
23.6 to comply with section 43A.38 shall be grounds for disciplinary action which may include  
23.7 termination of employment or removal from the board.

23.8 (b) In order to avoid the appearance of political bias or impropriety, the Minnesota Health  
23.9 Plan chief executive officer shall not:

23.10 (1) engage in leadership of, or employment by, a political party or a political organization;

23.11 (2) publicly endorse a political candidate;

23.12 (3) contribute to any political candidates or political parties and political organizations;

23.13 or

23.14 (4) attempt to avoid compliance with this subdivision by making contributions through  
23.15 a spouse or other family member.

23.16 (c) In order to avoid a conflict of interest, individuals specified in paragraph (a) shall  
23.17 not be currently employed by a medical provider or a pharmaceutical, medical insurance,  
23.18 or medical supply company. This paragraph does not apply to the five provider members  
23.19 of the board.

23.20 **Sec. 8. [62X.11] CONFLICT OF INTEREST COMMITTEE.**

23.21 (a) The board shall establish a conflict of interest committee to develop standards of  
23.22 practice for individuals or entities doing business with the Minnesota Health Plan, including  
23.23 but not limited to, board members, providers, and medical suppliers. The committee shall  
23.24 establish guidelines on the duty to disclose the existence of a financial interest and all  
23.25 material facts related to that financial interest to the committee.

23.26 (b) In considering the transaction or arrangement, if the committee determines a conflict  
23.27 of interest exists, the committee shall investigate alternatives to the proposed transaction  
23.28 or arrangement. After exercising due diligence, the committee shall determine whether the  
23.29 Minnesota Health Plan can obtain with reasonable efforts a more advantageous transaction  
23.30 or arrangement with a person or entity that would not give rise to a conflict of interest. If  
23.31 this is not reasonably possible under the circumstances, the committee shall make a  
23.32 recommendation to the board on whether the transaction or arrangement is in the best interest

24.1 of the Minnesota Health Plan, and whether the transaction is fair and reasonable. The  
24.2 committee shall provide the board with all material information used to make the  
24.3 recommendation. After reviewing all relevant information, the board shall decide whether  
24.4 to approve the transaction or arrangement.

24.5 Sec. 9. **[62X.12] OMBUDSMAN OFFICE FOR PATIENT ADVOCACY.**

24.6 Subdivision 1. **Creation of office.** (a) The Ombudsman Office for Patient Advocacy is  
24.7 created to represent the interests of the consumers of health care. The ombudsman shall  
24.8 help residents of the state secure the health care services and health care benefits they are  
24.9 entitled to under the laws administered by the Minnesota Health Board and advocate on  
24.10 behalf of and represent the interests of enrollees in entities created by this chapter and in  
24.11 other forums.

24.12 (b) The ombudsman shall be a patient advocate appointed by the governor, who serves  
24.13 in the unclassified service and may be removed only for just cause. The ombudsman must  
24.14 be selected without regard to political affiliation and must be knowledgeable about and have  
24.15 experience in health care services and administration.

24.16 (c) The ombudsman may gather information about decisions, acts, and other matters of  
24.17 the Minnesota Health Board, health care organization, or a health care program. A person  
24.18 may not serve as ombudsman while holding another public office.

24.19 (d) The budget for the ombudsman's office shall be determined by the legislature and is  
24.20 independent from the Minnesota Health Board. The ombudsman shall establish offices to  
24.21 provide convenient access to residents.

24.22 (e) The Minnesota Health Board has no oversight or authority over the ombudsman for  
24.23 patient advocacy.

24.24 Subd. 2. **Ombudsman's duties.** The ombudsman shall:

24.25 (1) ensure that patient advocacy services are available to all Minnesota residents;

24.26 (2) establish and maintain the grievance process according to section 62X.13;

24.27 (3) receive, evaluate, and respond to consumer complaints about the Minnesota Health  
24.28 Plan;

24.29 (4) establish a process to receive recommendations from the public about ways to improve  
24.30 the Minnesota Health Plan;

24.31 (5) develop educational and informational guides according to communication services  
24.32 under section 15.441, describing consumer rights and responsibilities;



25.1 (6) ensure the guides in clause (5) are widely available to consumers and specifically  
25.2 available in provider offices and health care facilities; and

25.3 (7) prepare an annual report about the consumer perspective on the performance of the  
25.4 Minnesota Health Plan, including recommendations for needed improvements.

25.5 **Sec. 10. [62X.13] GRIEVANCE SYSTEM.**

25.6 Subdivision 1. **Grievance system established.** The ombudsman shall establish a  
25.7 grievance system for complaints. The system shall provide a process that ensures adequate  
25.8 consideration of Minnesota Health Plan enrollee grievances and appropriate remedies.

25.9 Subd. 2. **Referral of grievances.** The ombudsman may refer any grievance that does  
25.10 not pertain to compliance with this chapter to the federal Centers for Medicare and Medicaid  
25.11 Services or any other appropriate local, state, and federal government entity for investigation  
25.12 and resolution.

25.13 Subd. 3. **Submittal by designated agents and providers.** A provider may join with,  
25.14 or otherwise assist, a complainant to submit the grievance to the ombudsman. A provider  
25.15 or an employee of a provider who, in good faith, joins with or assists a complainant in  
25.16 submitting a grievance is subject to the protections and remedies under sections 181.931 to  
25.17 181.935.

25.18 Subd. 4. **Review of documents.** The ombudsman may require additional information  
25.19 from health care providers or the board.

25.20 Subd. 5. **Written notice of disposition.** The ombudsman shall send a written notice of  
25.21 the final disposition of the grievance, and the reasons for the decision, to the complainant,  
25.22 to any provider who is assisting the complainant, and to the board, within 30 calendar days  
25.23 of receipt of the request for review unless the ombudsman determines that additional time  
25.24 is reasonably necessary to fully and fairly evaluate the relevant grievance. The ombudsman's  
25.25 order of corrective action shall be binding on the Minnesota Health Plan. A decision of the  
25.26 ombudsman is subject to de novo review by the district court.

25.27 Subd. 6. **Data.** Data on enrollees collected because an enrollee submits a complaint to  
25.28 the ombudsman are private data on individuals as defined in section 13.02, subdivision 12,  
25.29 but may be released to a provider who is the subject of the complaint or to the board for  
25.30 purposes of this section.

26.1 **Sec. 11. [62X.14] AUDITOR GENERAL FOR THE MINNESOTA HEALTH PLAN.**

26.2 Subdivision 1. **Establishment.** There is within the Office of the Legislative Auditor an  
26.3 auditor general for health care fraud and abuse for the Minnesota Health Plan who is  
26.4 appointed by the legislative auditor.

26.5 Subd. 2. **Duties.** The auditor general shall:

26.6 (1) investigate, audit, and review the financial and business records of the Minnesota  
26.7 Health Plan and the Minnesota Health Fund;

26.8 (2) investigate, audit, and review the financial and business records of individuals, public  
26.9 and private agencies and institutions, and private corporations that provide services or  
26.10 products to the Minnesota Health Plan, the costs of which are reimbursed by the Minnesota  
26.11 Health Plan;

26.12 (3) investigate allegations of misconduct on the part of an employee or appointee of the  
26.13 Minnesota Health Board and on the part of any provider of health care services that is  
26.14 reimbursed by the Minnesota Health Plan, and report any findings of misconduct to the  
26.15 attorney general;

26.16 (4) investigate fraud and abuse;

26.17 (5) arrange for the collection and analysis of data needed to investigate the inappropriate  
26.18 utilization of these products and services; and

26.19 (6) annually report recommendations for improvements to the Minnesota Health Plan  
26.20 to the board.

26.21 **Sec. 12. [62X.15] MINNESOTA HEALTH PLAN POLICIES AND PROCEDURES;**  
26.22 **RULEMAKING.**

26.23 Subdivision 1. **Exempt rules.** The Minnesota Health Plan policies and procedures are  
26.24 exempt from the Administrative Procedure Act but, to the extent authorized by law to adopt  
26.25 rules, the board may use the provisions of section 14.386, paragraph (a), clauses (1) and  
26.26 (3). Section 14.386, paragraph (b), does not apply to these rules.

26.27 Subd. 2. **Rulemaking procedures.** (a) Whenever the board determines that a rule should  
26.28 be adopted under this section establishing, modifying, or revoking a policy or procedure,  
26.29 the board shall publish in the State Register the proposed policy or procedure and shall  
26.30 afford interested persons a period of 30 days after publication to submit written data or  
26.31 comments.

27.1 (b) On or before the last day of the period provided for the submission of written data  
 27.2 or comments, any interested person may file with the board written objections to the proposed  
 27.3 rule, stating the grounds for objection and requesting a public hearing on those objections.  
 27.4 Within 30 days after the last day for filing objections, the board shall publish in the State  
 27.5 Register a notice specifying the policy or procedure to which objections have been filed  
 27.6 and a hearing requested and specifying a time and place for the hearing.

27.7 Subd. 3. **Rule adoption.** Within 60 days after the expiration of the period provided for  
 27.8 the submission of written data or comments, or within 60 days after the completion of any  
 27.9 hearing, the board shall issue a rule adopting, modifying, or revoking a policy or procedure,  
 27.10 or make a determination that a rule should not be adopted. The rule may contain a provision  
 27.11 delaying its effective date for such period as the board determines is necessary.

27.12 **Sec. 13. [62X.151] EXEMPTION FROM RULEMAKING.**

27.13 The board and its operation of the Minnesota Health Plan and the Minnesota Health  
 27.14 Fund is exempt from rulemaking under chapter 14.

27.15 Sec. 14. Minnesota Statutes 2022, section 14.03, subdivision 3, is amended to read:

27.16 **Subd. 3. **Rulemaking procedures.**** (a) The definition of a rule in section 14.02,  
 27.17 subdivision 4, does not include:

27.18 (1) rules concerning only the internal management of the agency or other agencies that  
 27.19 do not directly affect the rights of or procedures available to the public;

27.20 (2) an application deadline on a form; and the remainder of a form and instructions for  
 27.21 use of the form to the extent that they do not impose substantive requirements other than  
 27.22 requirements contained in statute or rule;

27.23 (3) the curriculum adopted by an agency to implement a statute or rule permitting or  
 27.24 mandating minimum educational requirements for persons regulated by an agency, provided  
 27.25 the topic areas to be covered by the minimum educational requirements are specified in  
 27.26 statute or rule;

27.27 (4) procedures for sharing data among government agencies, provided these procedures  
 27.28 are consistent with chapter 13 and other law governing data practices.

27.29 (b) The definition of a rule in section 14.02, subdivision 4, does not include:

27.30 (1) rules of the commissioner of corrections relating to the release, placement, term, and  
 27.31 supervision of inmates serving a supervised release or conditional release term, the internal

28.1 management of institutions under the commissioner's control, and rules adopted under  
 28.2 section 609.105 governing the inmates of those institutions;

28.3 (2) rules relating to weight limitations on the use of highways when the substance of the  
 28.4 rules is indicated to the public by means of signs;

28.5 (3) opinions of the attorney general;

28.6 (4) the data element dictionary and the annual data acquisition calendar of the Department  
 28.7 of Education to the extent provided by section 125B.07;

28.8 (5) the occupational safety and health standards provided in section 182.655;

28.9 (6) revenue notices and tax information bulletins of the commissioner of revenue;

28.10 (7) uniform conveyancing forms adopted by the commissioner of commerce under  
 28.11 section 507.09;

28.12 (8) standards adopted by the Electronic Real Estate Recording Commission established  
 28.13 under section 507.0945; ~~or~~

28.14 (9) the interpretive guidelines developed by the commissioner of human services to the  
 28.15 extent provided in chapter 245A; or

28.16 (10) rules, policies, and procedures adopted by the Minnesota Health Board under chapter  
 28.17 62X.

## 28.18 ARTICLE 7

### 28.19 IMPLEMENTATION

28.20 Section 1. **APPROPRIATION.**

28.21 \$..... in fiscal year 2024 is appropriated from the general fund to the Minnesota Health  
 28.22 Fund under the Minnesota Health Plan to provide start-up funding for the provisions of  
 28.23 chapter 62X.

28.24 Sec. 2. **EFFECTIVE DATE AND TRANSITION.**

28.25 Subdivision 1. **Effective date.** This act is effective the day following final enactment.  
 28.26 The commissioner of management and budget and the chief executive officer of the  
 28.27 Minnesota Health Plan shall regularly update the legislature on the status of planning,  
 28.28 implementation, and financing of this act.

28.29 Subd. 2. **Timing to implement.** The Minnesota Health Plan must be operational within  
 28.30 two years from the date of final enactment of this act.

29.1 Subd. 3. **Prohibition.** On and after the day the Minnesota Health Plan becomes  
29.2 operational, a health plan, as defined in Minnesota Statutes, section 62Q.01, subdivision 3,  
29.3 may not be sold in Minnesota for services provided by the Minnesota Health Plan.

29.4 Subd. 4. **Transition.** (a) The commissioners of health, human services, and commerce  
29.5 shall prepare an analysis of the state's capital expenditure needs for the purpose of assisting  
29.6 the board in adopting the statewide capital budget for the year following implementation.  
29.7 The commissioners shall submit this analysis to the board.

29.8 (b) The following timelines shall be implemented:

29.9 (1) the commissioner of health shall designate the health planning regions utilizing the  
29.10 criteria specified in Minnesota Statutes, section 62X.07, 30 days after the date of enactment  
29.11 of this act;

29.12 (2) the regional boards shall be established three months after the date of enactment of  
29.13 this act; and

29.14 (3) the Minnesota Health Board shall be established five months after the date of  
29.15 enactment of this act; and

29.16 (4) the commissioner of health, or the commissioner's designee, shall convene the first  
29.17 meeting of each of the regional boards and the Minnesota Health Board within 30 days after  
29.18 each of the boards has been established.

29.19 Subd. 5. **Report.** Within one year of the effective date of chapter 62X, DEED shall  
29.20 provide to the Minnesota Health Board, the governor, and the chairs and ranking members  
29.21 of the legislative committees with jurisdiction over health, human services, and commerce  
29.22 a report spelling out the appropriations and legislation necessary to assist all affected  
29.23 individuals and communities through the transition.