SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 1402

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DATE	D-PG	OFFICIAL STATUS
02/13/2025	388	Introduction and first reading Referred to Health and Human Services
02/27/2025	579	Authors added Abeler; Boldon
03/03/2025	586a	Comm report: To pass as amended and re-refer to Taxes
	626	Author stricken Lieske
04/02/2025	1270	Comm report: No recommendation, re-referred to Health and Human Services See First Special Session, HF2

A bill for an act

relating to health insurance; establishing medical assistance rate adjustments for physician and professional services; increasing rates for certain residential services; requiring a statewide reimbursement rate for behavioral health home services; imposing an assessment on health plan companies to provide nonfederal funds for medical assistance; authorizing the commissioner of human services to seek federal waivers; amending Minnesota Statutes 2024, sections 256.969, subdivision 2b; 256B.0757, subdivision 5, by adding a subdivision; 256B.76, subdivisions 1, 6; 256B.761; proposing coding for new law in Minnesota Statutes, chapters 256B; 295; repealing Minnesota Statutes 2024, section 256B.0625, subdivision 38.

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

Section 1. Minnesota Statutes 2024, section 256.969, subdivision 2b, is amended to read:

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

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

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

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

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

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

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

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

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

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

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

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

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

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

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

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year or years and the next base year or years. In any year that inpatient claims volume falls below the threshold required to ensure a statistically valid sample of claims, the commissioner may combine claims data from two consecutive years to serve as the base year. Years in which inpatient claims volume is reduced or altered due to a pandemic or other public health emergency shall not be used as

a base year or part of a base year if the base year includes more than one year. Changes in costs between base years shall be measured using the lower of the hospital cost index defined in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per claim. The commissioner shall establish the base year for each rebasing period considering the most recent year or years for which filed Medicare cost reports are available, except that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the following criteria:

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

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

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

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

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

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

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

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

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

(6) geographic location.

(k) Subject to subdivision 2g, effective for discharges occurring on or after January 1, 2024, the rates paid to hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific to each hospital that qualifies for a medical education and research cost distribution under section 62J.692, subdivision 4, paragraph (a).

(l) Effective for discharges occurring on or after January 1, 2028, the commissioner must increase:

(1) payments for inpatient behavioral health services provided by hospitals paid under the DRG methodology by increasing the adjustment for behavioral health services under section 256.969, subdivision 2b, paragraph (e); and

(2) capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increase provided under this paragraph. Managed care and county-based purchasing plans must use the capitation rate increase provided under this clause to increase payment rates for inpatient behavioral health services provided by hospitals paid under the DRG methodology. The commissioner must monitor the effect of this rate increase on enrollee access to behavioral health services. If for any contract year federal approval is not received for this clause, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this clause. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this clause. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph.

Sec. 2. Minnesota Statutes 2024, section 256B.0757, subdivision 5, is amended to read:

Subd. 5. **Payments.** (a) The commissioner shall make payments to each designated provider for the provision of health home services described in subdivision 3 to each eligible individual under subdivision 2 that selects the health home as a provider. This paragraph expires on the date that paragraph (b) becomes effective.

(b) Effective January 1, 2028, or upon federal approval, whichever is later, the commissioner shall make payments to each designated provider for the provision of health home services described in subdivision 3, except for behavioral health services, to each eligible individual under subdivision 2 who selects the health home as a provider.

Sec. 3. Minnesota Statutes 2024, section 256B.0757, is amended by adding a subdivision to read:

Subd. 5a. **Payments for behavioral health home services.** (a) Notwithstanding subdivision 5, the commissioner must implement a single statewide reimbursement rate for behavioral health home services under this section. The rate must be no less than $425 per member per month. The commissioner must adjust the statewide reimbursement rate annually according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year.

(b) The commissioner must review and update the behavioral health home services rate under paragraph (a) at least every four years. The updated rate must account for the average hours required for behavioral health home team members spent providing services and the Department of Labor prevailing wage for required behavioral health home team members. The updated rate must ensure that behavioral health home services rates are sufficient to allow providers to meet required certifications, training, and practice transformation standards; staff qualification requirements; and service delivery standards.

(c) This section is effective January 1, 2028, or upon federal approval, whichever is later.

Sec. 4. **[256B.757] REIMBURSEMENT RATES FOR OBSTETRIC AND GYNECOLOGIC SERVICES.**

Subdivision 1. **Obstetric and gynecologic minimum rate.** Effective for services rendered on or after January 1, 2026, or the date of federal approval, whichever is later, rates for

obstetric and gynecologic services reimbursed under the resource-based relative value scale must be at least equal to 100 percent of the Medicare Physician Fee Schedule.

Subd. 2. **Capitation payments.** Effective for services rendered on or after January 1, 2026, or the date of federal approval, whichever is later, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increases provided under this section. Managed care plans and county-based purchasing plans must use the capitation rate increase provided under this subdivision to increase payment rates to the providers corresponding to the rate increases. The commissioner must monitor the effect of this rate increase on enrollee access to services under this section. If for any contract year federal approval is not received for this subdivision, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this subdivision. Contracts between managed care plans and county-based purchasing plans and providers to whom this subdivision applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this subdivision. Payment recoveries must not exceed the amount equal to any increase in rates that results from this subdivision.

Subd. 3. **Medicare physician fee schedule.** For purposes of this section, the applicable Medicare Physician Fee Schedule is the most recent Medicare Physician Fee Schedule Final Rule issued by the Centers for Medicare and Medicaid Services in effect at the time the service was rendered.

EFFECTIVE DATE. Subdivision 3 is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. Minnesota Statutes 2024, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician and professional services reimbursement.** ~~(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:~~

~~(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;~~

~~(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and~~

~~(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.~~

~~(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.~~

~~(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice registered nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.~~

~~(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice registered nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.~~

~~(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from~~

~~the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.~~

~~(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.~~

~~(g)~~ (a) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

~~(h)~~ (b) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

~~(i)~~ (c) The commissioner may reimburse physicians and other licensed professionals for costs incurred to pay the fee for testing newborns who are medical assistance enrollees for heritable and congenital disorders under section 144.125, subdivision 1, paragraph (c), when the sample is collected outside of an inpatient hospital or freestanding birth center and the cost is not recognized by another payment source.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval of the amendments in this act to section 256B.76, subdivision 6, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2024, section 256B.76, subdivision 6, is amended to read:

Subd. 6. **Medicare relative value units.** (a) Effective for services rendered on or after January 1, 2007, the commissioner shall make payments for physician and professional services based on the Medicare relative value units (RVUs). This change shall be budget neutral and the cost of implementing RVUs will be incorporated in the established conversion factor. This paragraph expires on the date that paragraph (b) becomes effective.

(b) Effective January 1, 2026, or upon federal approval, whichever is later, and effective for services rendered on or after January 1, 2007, the commissioner shall make payments for physician and professional services based on the Medicare relative value units (RVUs).

~~(b)~~ (c) Effective for services rendered on or after January 1, 2025, rates for mental health services reimbursed under the resource-based relative value scale (RBRVS) must be equal to 83 percent of the Medicare Physician Fee Schedule. This paragraph expires on the date that paragraph (d) becomes effective.

(d) Effective January 1, 2026, or upon federal approval, whichever is later, and effective for services rendered on or after January 1, 2026, or the date of federal approval, whichever is later, rates for all physician and professional services must be at least equal to 100 percent of the Medicare Physician Fee Schedule.

~~(c)~~ (e) Effective for services rendered on or after January 1, 2025, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increases provided under this subdivision. Managed care plans and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to the providers corresponding to the rate increases. The commissioner must monitor the effect of this rate increase on enrollee access to services under this subdivision. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this paragraph. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph.

(f) For purposes of this subdivision, the applicable Medicare Physician Fee Schedule is the most recent Medicare Physician Fee Schedule Final Rule issued by the Centers for Medicare and Medicaid Services in effect at the time the service was rendered.

EFFECTIVE DATE. Paragraph (f) is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 7. Minnesota Statutes 2024, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256K.10. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

(d) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

(e) Effective for services rendered on or after January 1, 2024, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, except for adult day treatment services under section 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services under section 256B.0949; and substance use disorder services under chapter 254B, must be increased by three percent from the rates in effect on December 31, 2023. Effective for services rendered on or after January 1, 2025, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18; early intensive developmental behavioral intervention services under section

256B.0949; and substance use disorder services under chapter 254B, must be annually adjusted according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year. For payments made in accordance with this paragraph, if and to the extent that the commissioner identifies that the state has received federal financial participation for behavioral health services in excess of the amount allowed under United States Code, title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state money and maintain the full payment rate under this paragraph. This paragraph does not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, and rates that are negotiated with the county. This paragraph expires upon legislative implementation of the new rate methodology resulting from the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18.

(f) Effective January 1, 2024, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the behavioral health service rate increase provided in paragraph (e). Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to behavioral health services providers. The commissioner must monitor the effect of this rate increase on enrollee access to behavioral health services. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision.

(g) Effective for services rendered on or after January 1, 2026, or the date of federal approval, whichever is later:

(1) rates for mental health services reimbursed under the resource-based relative value scale must be at least equal to 100 percent of the Medicare Physician Fee Schedule; and

(2) the commissioner must increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increases provided under this paragraph. Managed care plans and county-based purchasing plans must use the capitation rate increase provided under this clause to increase payment rates to the providers corresponding to the

rate increases. The commissioner must monitor the effect of this rate increase on enrollee access to services under this paragraph. If for any contract year federal approval is not received for this clause, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this clause. Contracts between managed care plans and county-based purchasing plans and providers to whom this clause applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this clause. Payment recoveries must not exceed the amount equal to any increase in rates that results from this clause.

(h) Effective for services under this section billed and coded under Healthcare Common Procedure Coding System H, T, and S, and rendered on or after January 1, 2027, or the date of federal approval, whichever is later, the commissioner must increase reimbursement rates as necessary to align with the Medicare Physician Fee Schedule.

(i) Effective for children's therapeutic supports and services under section 256B.0943, subdivision 2, and services under section 245.488, rendered on or after January 1, 2026, or the date of federal approval, whichever is later, the commissioner must increase:

(1) reimbursement rates as necessary to align with the Medicare Physician Fee Schedule; and

(2) capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increases provided under this paragraph. Managed care plans and county-based purchasing plans must use the capitation rate increase provided under this clause to increase payment rates to the providers corresponding to the rate increases. The commissioner must monitor the effect of this rate increase on enrollee access to services under this paragraph. If for any contract year federal approval is not received for this clause, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this clause. Contracts between managed care plans and county-based purchasing plans and providers to whom this clause applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this clause. Payment recoveries must not exceed the amount equal to any increase in rates that results from this clause.

(j) Paragraph (i) does not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, psychiatric residential treatment facilities, and children's residential services and rates that are negotiated with the county.

(k) For behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, except for adult day treatment services under section 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services under section 256B.0949; and substance use disorder services under chapter 254B, managed care plans and county-based purchasing plans must reimburse the providers at a rate that is at least equal to the fee-for-service payment rate. The commissioner must monitor the effect of this requirement on the rate of access to the services delivered by providers of behavioral health services.

(l) For purposes of this section, the applicable Medicare Physician Fee Schedule is the most recent Medicare Physician Fee Schedule Final Rule issued by the Centers for Medicare and Medicaid Services in effect at the time the service was rendered.

EFFECTIVE DATE. Paragraphs (j) to (l) are effective January 1, 2026, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 8. **[256B.7662] REIMBURSEMENT RATES FOR PRIMARY CARE SERVICES.**

Subdivision 1. **Primary care minimum rate.** Effective for services rendered on or after January 1, 2026, or the date of federal approval, whichever is later, rates for primary care services reimbursed under the resource-based relative value scale must be at least equal to 100 percent of the Medicare Physician Fee Schedule.

Subd. 2. **Capitation payments.** Effective for services rendered on or after January 1, 2026, or the date of federal approval, whichever is later, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increases provided under this section. Managed care plans and county-based purchasing plans must use the capitation rate increase provided under this subdivision to increase payment rates to the providers corresponding to the rate increases. The commissioner must monitor the effect of this rate increase on enrollee access to services under this section. If for any contract year federal approval is not received for this subdivision, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this subdivision. Contracts between managed care plans and county-based purchasing plans and providers to whom this subdivision applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this subdivision. Payment recoveries must not exceed the amount equal to any increase in rates that results from this subdivision.

Subd. 3. **Medicare physician fee schedule.** For purposes of this section, the applicable Medicare Physician Fee Schedule is the most recent Medicare Physician Fee Schedule Final Rule issued by the Centers for Medicare and Medicaid Services in effect at the time the service was rendered.

EFFECTIVE DATE. Subdivision 3 is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. **[295.525] MCO ASSESSMENT ON HEALTH PLAN COMPANIES.**

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

(b) "Base year" means January 1, 2025, to December 31, 2025.

(c) "Commissioner" means the commissioner of human services.

(d) "Enrollee" has the meaning given in section 62Q.01, except that enrollee does not include:

(1) an individual enrolled in a Medicare plan;

(2) a plan-to-plan enrollee; or

(3) an individual enrolled in a health plan pursuant to the Federal Employees Health Benefits Act of 1959, Public Law 86-382, as amended, to the extent the imposition of the assessment under this section is preempted pursuant to United States Code, title 5, section 8909, subsection (f).

(e) "Health plan" has the meaning given in section 62Q.01.

(f) "Health plan company" has the meaning given in section 62Q.01.

(g) "Medical assistance" means the medical assistance program established under chapter 256B.

(h) "Medical assistance enrollee" means an enrollee in medical assistance for whom the department of human services directly pays the health plan company a capitated payment.

(i) "Plan-to-plan enrollee" means an individual who receives coverage for health care services through a health plan pursuant to a subcontract from another health plan.

Subd. 2. **MCO assessment.** (a) An annual assessment is imposed on health plan companies for calendar years 2026 to 2029. The total annual assessment amount is equal

to the sum of the amounts assessed for medical assistance enrollees under paragraph (b) and for nonmedical assistance enrollees under paragraph (c).

(b) The amount assessed for medical assistance enrollees is equal to the sum of the following:

(1) for medical assistance enrollees 0 to 60,000, $0 per enrollee;

(2) for medical assistance enrollees 60,001 to 100,000, $340 per enrollee;

(3) for medical assistance enrollees 100,001 to 200,000, $365 per enrollee; and

(4) for medical assistance enrollees 200,001 to 350,000, $380 per enrollee.

(c) The amount assessed for nonmedical assistance enrollees is equal to the sum of the following:

(1) for nonmedical assistance enrollees 0 to 60,000, $0 per enrollee;

(2) for nonmedical assistance enrollees 60,001 to 100,000, 50 cents per enrollee;

(3) for nonmedical assistance enrollees 100,001 to 200,000, 75 cents per enrollee; and

(4) for nonmedical assistance enrollees 200,001 to 350,000, $1 per enrollee.

(d) The commissioner may, after consultation with health plan companies likely to be affected, modify the rate of assessment, as set forth in paragraphs (a) to (c), as necessary to comply with federal law, obtain or maintain a waiver under Code of Federal Regulations, title 42, section 433.72, or to otherwise maximize under this section federal financial participation for medical assistance.

(e) Unpaid assessment amounts accrue interest at a rate of ten percent per annum, beginning the day following the assessment payment's due date. A penalty, equal to the total accrued interest charge, is imposed monthly on payments 60 days or more overdue until the payment, penalty, and interest are paid in full.

Subd. 3. **Assessment computation; collection.** (a) The commissioner must determine the following for each health plan company:

(1) total cumulative enrollment for the base year;

(2) total Medicare cumulative enrollment for the base year;

(3) total medical assistance cumulative enrollment for the base year;

(4) total plan-to-plan cumulative enrollment for the base year;

(5) total cumulative enrollment through the Federal Employees Health Benefits Act of 1959, Public Law 86-382, as amended, for the base year; and

(6) total other cumulative enrollment for the base year that is not otherwise counted in clauses (2) to (5).

(b) Health plan companies must provide any information requested by the commissioner for the purpose of this subdivision, provided that the commissioner determines such information is necessary to accurately determine the information in paragraph (a).

(c) The commissioner may correct errors in data provided to the commissioner by a health plan company to the extent necessary to accurately determine the information in paragraph (a).

(d) For purposes of calculating the information in paragraph (a) for a health plan company, the commissioner must count any individual that was an enrollee of a health plan at any point of the base year, regardless of the enrollee's duration as an enrollee of the health plan.

(e) The commissioner must use the information in paragraph (a) to compute the assessment for each health plan company.

(f) The commissioner must collect the annual assessment for each health plan company in four equal installments, in the manner and on the schedule determined by the commissioner. The commissioner is prohibited from collecting any amount under this section until 20 days after the commissioner has notified the health plan company of:

(1) the effective date of this section;

(2) the assessment due dates for the applicable calendar year; and

(3) the annual assessment amount.

(g) The commissioner may waive all or part of the interest or penalty imposed on a health plan company under subdivision 2, paragraph (e), if the commissioner determines the interest or penalty is likely to create an undue financial hardship on the health plan company or a significant financial difficulty in providing necessary services to medical assistance enrollees. A waiver under this paragraph must be contingent on the health plan company's agreement to make assessment payments on an alternative schedule, determined by the commissioner, that accounts for the health plan company's finances and the potential impact on the delivery of services to medical assistance enrollees.

(h) In the event of a merger, acquisition, or other transaction that results in the transfer of health plan responsibility to another health plan company or similar entity during calendar

years 2026 to 2029, the surviving, acquiring, or controlling health plan company or similar entity shall be responsible for paying the full assessment amount as provided in this section that would have been the responsibility of the health plan company to which that full assessment amount was assessed upon the effective date of the transaction. If a transaction results in the transfer of health plan responsibility for only some of a health plan's enrollees under this section but not all enrollees, the full assessment amount as provided in this section remains the responsibility of that health plan company to which that full assessment amount was assessed.

Subd. 4. **MCO assessment expenditures.** (a) All amounts collected by the commissioner under this section must be deposited in the health care access fund.

(b) All amounts collected by the commissioner under this section are annually appropriated to the commissioner to provide nonfederal funds for medical assistance. The assessment funds must be used to supplement funds for medical assistance from the general fund.

(c) The commissioner must provide an annual report to all health plan companies, in a time and manner determined by the commissioner. The report must identify the assessments imposed on each health plan company pursuant to this section, account for all funds raised by the MCO assessment, and provide an itemized accounting of expenditures from the fund.

Subd. 5. **Expiration.** This section expires June 30, 2030.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval for the assessment established in this section to be considered a permissible health care-related tax under Code of Federal Regulations, title 42, section 433.68, eligible for federal financial participation, including but not limited to federal approval of a waiver under Code of Federal Regulations, title 42, section 433.72, if such waiver is necessary to receive health care-related taxes without a reduction in federal financial participation, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. **FEDERAL APPROVAL; WAIVERS.**

(a) The commissioner must request, as the commissioner determines necessary, federal approval for the MCO assessment on health plan companies established in this act to be considered a permissible health care-related tax under Code of Federal Regulations, title 42, section 433.68, eligible for federal financial participation.

(b) To obtain the federal approval under paragraph (a), the commissioner may apply for a waiver of the federal broad-based requirement for health care-related taxes, uniform requirement for health care-related taxes, and any other provision of federal law necessary to implement Minnesota Statutes, section 295.525.

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

Sec. 11. **REPEALER.**

Minnesota Statutes 2024, section 256B.0625, subdivision 38, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

256B.0625 COVERED SERVICES.

Subd. 38. **Payments for mental health services.** Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by physician assistants shall be 80.4 percent of the base rate paid to psychiatrists.