

114.7 **ARTICLE 3**

114.8 **HEALTH CARE**

114.9 Section 1. Minnesota Statutes 2022, section 252.27, subdivision 2a, is amended to read:

114.10 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child,
114.11 not including a child determined eligible for medical assistance without consideration of
114.12 parental income under the Tax Equity and Fiscal Responsibility Act (TEFRA) option or a
114.13 child accessing home and community-based waiver services, must contribute to the cost of
114.14 services used by making monthly payments on a sliding scale based on income, unless the
114.15 child is married or has been married, parental rights have been terminated, or the child's
114.16 adoption is subsidized according to chapter 259A or through title IV-E of the Social Security
114.17 Act. The parental contribution is a partial or full payment for medical services provided for
114.18 diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal
114.19 care services as defined in United States Code, title 26, section 213, needed by the child
114.20 with a chronic illness or disability.

114.21 (b) For households with adjusted gross income equal to or greater than 275 percent of
114.22 federal poverty guidelines, the parental contribution shall be computed by applying the
114.23 following schedule of rates to the adjusted gross income of the natural or adoptive parents:

114.24 (1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty
114.25 guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental
114.26 contribution shall be determined using a sliding fee scale established by the commissioner
114.27 of human services which begins at 1.65 percent of adjusted gross income at 275 percent of
114.28 federal poverty guidelines and increases to 4.5 percent of adjusted gross income for those
114.29 with adjusted gross income up to 545 percent of federal poverty guidelines;

114.30 (2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines
114.31 and less than 675 percent of federal poverty guidelines, the parental contribution shall be
114.32 4.5 percent of adjusted gross income;

115.1 (3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty
115.2 guidelines and less than 975 percent of federal poverty guidelines, the parental contribution
115.3 shall be determined using a sliding fee scale established by the commissioner of human
115.4 services which begins at 4.5 percent of adjusted gross income at 675 percent of federal
115.5 poverty guidelines and increases to 5.99 percent of adjusted gross income for those with
115.6 adjusted gross income up to 975 percent of federal poverty guidelines; and

115.7 (4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty
115.8 guidelines, the parental contribution shall be 7.49 percent of adjusted gross income.

115.9 If the child lives with the parent, the annual adjusted gross income is reduced by \$2,400
115.10 prior to calculating the parental contribution. If the child resides in an institution specified
115.11 in section 256B.35, the parent is responsible for the personal needs allowance specified
115.12 under that section in addition to the parental contribution determined under this section.

115.13 The parental contribution is reduced by any amount required to be paid directly to the child
115.14 pursuant to a court order, but only if actually paid.

115.15 (c) The household size to be used in determining the amount of contribution under
115.16 paragraph (b) includes natural and adoptive parents and their dependents, including the
115.17 child receiving services. Adjustments in the contribution amount due to annual changes in
115.18 the federal poverty guidelines shall be implemented on the first day of July following
115.19 publication of the changes.

115.20 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
115.21 natural or adoptive parents determined according to the previous year's federal tax form,
115.22 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
115.23 have been used to purchase a home shall not be counted as income.

115.24 (e) The contribution shall be explained in writing to the parents at the time eligibility
115.25 for services is being determined. The contribution shall be made on a monthly basis effective
115.26 with the first month in which the child receives services. Annually upon redetermination
115.27 or at termination of eligibility, if the contribution exceeded the cost of services provided,
115.28 the local agency or the state shall reimburse that excess amount to the parents, either by
115.29 direct reimbursement if the parent is no longer required to pay a contribution, or by a
115.30 reduction in or waiver of parental fees until the excess amount is exhausted. All
115.31 reimbursements must include a notice that the amount reimbursed may be taxable income
115.32 if the parent paid for the parent's fees through an employer's health care flexible spending
115.33 account under the Internal Revenue Code, section 125, and that the parent is responsible
115.34 for paying the taxes owed on the amount reimbursed.

116.1 (f) The monthly contribution amount must be reviewed at least every 12 months; when
116.2 there is a change in household size; and when there is a loss of or gain in income from one
116.3 month to another in excess of ten percent. The local agency shall mail a written notice 30
116.4 days in advance of the effective date of a change in the contribution amount. A decrease in
116.5 the contribution amount is effective in the month that the parent verifies a reduction in
116.6 income or change in household size.

116.7 (g) Parents of a minor child who do not live with each other shall each pay the
116.8 contribution required under paragraph (a). An amount equal to the annual court-ordered
116.9 child support payment actually paid on behalf of the child receiving services shall be deducted
116.10 from the adjusted gross income of the parent making the payment prior to calculating the
116.11 parental contribution under paragraph (b).

116.12 (h) The contribution under paragraph (b) shall be increased by an additional five percent
116.13 if the local agency determines that insurance coverage is available but not obtained for the
116.14 child. For purposes of this section, "available" means the insurance is a benefit of employment
116.15 for a family member at an annual cost of no more than five percent of the family's annual
116.16 income. For purposes of this section, "insurance" means health and accident insurance
116.17 coverage, enrollment in a nonprofit health service plan, health maintenance organization,
116.18 self-insured plan, or preferred provider organization.

116.19 Parents who have more than one child receiving services shall not be required to pay
116.20 more than the amount for the child with the highest expenditures. There shall be no resource
116.21 contribution from the parents. The parent shall not be required to pay a contribution in
116.22 excess of the cost of the services provided to the child, not counting payments made to
116.23 school districts for education-related services. Notice of an increase in fee payment must
116.24 be given at least 30 days before the increased fee is due.

116.25 (i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if, in
116.26 the 12 months prior to July 1:

116.27 (1) the parent applied for insurance for the child;

116.28 (2) the insurer denied insurance;

116.29 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a
116.30 complaint or appeal, in writing, to the commissioner of health or the commissioner of
116.31 commerce, or litigated the complaint or appeal; and

116.32 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

116.33 For purposes of this section, "insurance" has the meaning given in paragraph (h).

117.1 A parent who has requested a reduction in the contribution amount under this paragraph
117.2 shall submit proof in the form and manner prescribed by the commissioner or county agency,
117.3 including; but not limited to; the insurer's denial of insurance, the written letter or complaint
117.4 of the parents, court documents, and the written response of the insurer approving insurance.
117.5 The determinations of the commissioner or county agency under this paragraph are not rules
117.6 subject to chapter 14.

117.7 Sec. 2. Minnesota Statutes 2022, section 256B.04, is amended by adding a subdivision to
117.8 read:

117.9 Subd. 26. **Notice of employed persons with disabilities program.** At the time of initial
117.10 enrollment and at least annually thereafter, the commissioner shall provide information on
117.11 the medical assistance program for employed persons with disabilities under section
117.12 256B.057, subdivision 9, to all medical assistance enrollees who indicate they have a
117.13 disability.

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

117.15 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical
117.16 assistance, a person must not individually own more than \$3,000 in assets, or if a member

THE FOLLOWING SECTION WAS MOVED IN FROM UES2934-2, ARTICLE
1, SECTION 13
UES2934-2

20.21 Sec. 13. Minnesota Statutes 2022, section 256B.056, subdivision 3, is amended to read:

20.22 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical
20.23 assistance, a person must not individually own more than \$3,000 in assets, or if a member

117.17 of a household with two family members, husband and wife, or parent and child, the
 117.18 household must not own more than \$6,000 in assets, plus \$200 for each additional legal
 117.19 dependent. In addition to these maximum amounts, an eligible individual or family may
 117.20 accrue interest on these amounts, but they must be reduced to the maximum at the time of
 117.21 an eligibility redetermination. The accumulation of the clothing and personal needs allowance
 117.22 according to section 256B.35 must also be reduced to the maximum at the time of the
 117.23 eligibility redetermination. The value of assets that are not considered in determining
 117.24 eligibility for medical assistance is the value of those assets excluded under the Supplemental
 117.25 Security Income program for aged, blind, and disabled persons, with the following
 117.26 exceptions:

117.27 (1) household goods and personal effects are not considered;

117.28 (2) capital and operating assets of a trade or business that the local agency determines
 117.29 are necessary to the person's ability to earn an income are not considered;

117.30 (3) motor vehicles are excluded to the same extent excluded by the Supplemental Security
 117.31 Income program;

118.1 (4) assets designated as burial expenses are excluded to the same extent excluded by the
 118.2 Supplemental Security Income program. Burial expenses funded by annuity contracts or
 118.3 life insurance policies must irrevocably designate the individual's estate as contingent
 118.4 beneficiary to the extent proceeds are not used for payment of selected burial expenses;

118.5 (5) for a person who no longer qualifies as an employed person with a disability due to
 118.6 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,
 118.7 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility
 118.8 as an employed person with a disability, to the extent that the person's total assets remain
 118.9 within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

118.10 (6) a designated employment incentives asset account is disregarded when determining
 118.11 eligibility for medical assistance for a person age 65 years or older under section 256B.055,
 118.12 subdivision 7. An employment incentives asset account must only be designated by a person
 118.13 who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a
 118.14 24-consecutive-month period. A designated employment incentives asset account contains
 118.15 qualified assets owned by the person ~~and the person's spouse~~ in the last month of enrollment
 118.16 in medical assistance under section 256B.057, subdivision 9. Qualified assets include
 118.17 retirement and pension accounts, medical expense accounts, and up to \$17,000 of the person's
 118.18 other nonexcluded liquid assets. An employment incentives asset account is no longer
 118.19 designated when a person loses medical assistance eligibility for a calendar month or more
 118.20 before turning age 65. A person who loses medical assistance eligibility before age 65 can
 118.21 establish a new designated employment incentives asset account by establishing a new
 118.22 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. ~~The~~
 118.23 ~~income of a spouse of a person enrolled in medical assistance under section 256B.057,~~
 118.24 ~~subdivision 9, during each of the 24 consecutive months before the person's 65th birthday~~
 118.25 ~~must be disregarded when determining eligibility for medical assistance under section~~

20.24 of a household with two family members, husband and wife, or parent and child, the
 20.25 household must not own more than \$6,000 in assets, plus \$200 for each additional legal
 20.26 dependent. In addition to these maximum amounts, an eligible individual or family may
 20.27 accrue interest on these amounts, but they must be reduced to the maximum at the time of
 20.28 an eligibility redetermination. The accumulation of the clothing and personal needs allowance
 20.29 according to section 256B.35 must also be reduced to the maximum at the time of the
 20.30 eligibility redetermination. The value of assets that are not considered in determining
 20.31 eligibility for medical assistance is the value of those assets excluded under the Supplemental
 21.1 Security Income program for aged, blind, and disabled persons, with the following
 21.2 exceptions:

21.3 (1) household goods and personal effects are not considered;

21.4 (2) capital and operating assets of a trade or business that the local agency determines
 21.5 are necessary to the person's ability to earn an income are not considered;

21.6 (3) motor vehicles are excluded to the same extent excluded by the Supplemental Security
 21.7 Income program;

21.8 (4) assets designated as burial expenses are excluded to the same extent excluded by the
 21.9 Supplemental Security Income program. Burial expenses funded by annuity contracts or
 21.10 life insurance policies must irrevocably designate the individual's estate as contingent
 21.11 beneficiary to the extent proceeds are not used for payment of selected burial expenses;

21.12 (5) for a person who no longer qualifies as an employed person with a disability due to
 21.13 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,
 21.14 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility
 21.15 as an employed person with a disability, to the extent that the person's total assets remain
 21.16 within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

21.17 (6) a designated employment incentives asset account is disregarded when determining
 21.18 eligibility for medical assistance for a person age 65 years or older under section 256B.055,
 21.19 subdivision 7. An employment incentives asset account must only be designated by a person
 21.20 who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a
 21.21 24-consecutive-month period. A designated employment incentives asset account contains
 21.22 qualified assets owned by the person ~~and the person's spouse~~ in the last month of enrollment
 21.23 in medical assistance under section 256B.057, subdivision 9. Qualified assets include
 21.24 retirement and pension accounts, medical expense accounts, and up to \$17,000 of the person's
 21.25 other nonexcluded liquid assets. An employment incentives asset account is no longer
 21.26 designated when a person loses medical assistance eligibility for a calendar month or more
 21.27 before turning age 65. A person who loses medical assistance eligibility before age 65 can
 21.28 establish a new designated employment incentives asset account by establishing a new
 21.29 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. ~~The~~
 21.30 ~~income of a spouse of a person enrolled in medical assistance under section 256B.057,~~
 21.31 ~~subdivision 9, during each of the 24 consecutive months before the person's 65th birthday~~
 21.32 ~~must be disregarded when determining eligibility for medical assistance under section~~

118.26 ~~256B.055, subdivision 7.~~ Persons eligible under this clause are not subject to the provisions
118.27 in section 256B.059; and

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

118.32 (b) No asset limit shall apply to persons eligible under section sections 256B.055,
118.33 subdivision 15, and 256B.057, subdivision 9.

119.1 **EFFECTIVE DATE.** This section is effective January 1, 2024, or upon federal approval,
119.2 whichever occurs later. The commissioner of human services shall notify the revisor of
119.3 statutes when federal approval is obtained.

119.4 Sec. 4. Minnesota Statutes 2022, section 256B.057, subdivision 9, is amended to read:

119.5 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for
119.6 a person who is employed and who:

119.7 ~~(1)~~ but for excess earnings or assets, meets the definition of disabled under the
119.8 Supplemental Security Income program;

119.9 ~~(2) meets the asset limits in paragraph (d); and~~

119.10 ~~(3) pays a premium and other obligations under paragraph (e).~~

119.11 (b) For purposes of eligibility, there is a \$65 earned income disregard. To be eligible
119.12 for medical assistance under this subdivision, a person must have more than \$65 of earned
119.13 income. Earned income must have Medicare, Social Security, and applicable state and
119.14 federal taxes withheld. The person must document earned income tax withholding. Any
119.15 spousal income or assets shall be disregarded for purposes of eligibility and premium
119.16 determinations.

119.17 (c) After the month of enrollment, a person enrolled in medical assistance under this
119.18 subdivision who:

119.19 (1) is temporarily unable to work and without receipt of earned income due to a medical
119.20 condition, as verified by a physician, advanced practice registered nurse, or physician
119.21 assistant; or

119.22 (2) loses employment for reasons not attributable to the enrollee, and is without receipt
119.23 of earned income may retain eligibility for up to four consecutive months after the month
119.24 of job loss. To receive a four-month extension, enrollees must verify the medical condition
119.25 or provide notification of job loss. All other eligibility requirements must be met and the
119.26 enrollee must pay all calculated premium costs for continued eligibility.

21.33 ~~256B.055, subdivision 7.~~ Persons eligible under this clause are not subject to the provisions
21.34 in section 256B.059; and

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

22.5 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
22.6 15.

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

THE FOLLOWING SECTION WAS MOVED IN FROM UES2934-2, ARTICLE 1, SECTION 14

22.8 Sec. 14. Minnesota Statutes 2022, section 256B.057, subdivision 9, is amended to read:

22.9 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for
22.10 a person who is employed and who:

22.11 (1) but for excess earnings or assets, meets the definition of disabled under the
22.12 Supplemental Security Income program;

22.13 (2) meets the asset limits in paragraph (d); and

22.14 (3) pays a premium and other obligations under paragraph (e).

22.15 (b) For purposes of eligibility, there is a \$65 earned income disregard. To be eligible
22.16 for medical assistance under this subdivision, a person must have more than \$65 of earned
22.17 income. Earned income must have Medicare, Social Security, and applicable state and
22.18 federal taxes withheld. The person must document earned income tax withholding. Any
22.19 spousal income or assets shall be disregarded for purposes of eligibility and premium
22.20 determinations.

22.21 (c) After the month of enrollment, a person enrolled in medical assistance under this
22.22 subdivision who:

22.23 (1) is temporarily unable to work and without receipt of earned income due to a medical
22.24 condition, as verified by a physician, advanced practice registered nurse, or physician
22.25 assistant; or

22.26 (2) loses employment for reasons not attributable to the enrollee, and is without receipt
22.27 of earned income may retain eligibility for up to four consecutive months after the month
22.28 of job loss. To receive a four-month extension, enrollees must verify the medical condition
22.29 or provide notification of job loss. All other eligibility requirements must be met and the
22.30 enrollee must pay all calculated premium costs for continued eligibility.

119.27 ~~(d) For purposes of determining eligibility under this subdivision, a person's assets must~~
119.28 ~~not exceed \$20,000, excluding:~~

119.29 ~~(1) all assets excluded under section 256B.056;~~

119.30 ~~(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh~~
119.31 ~~plans, and pension plans;~~

120.1 ~~(3) medical expense accounts set up through the person's employer; and~~

120.2 ~~(4) spousal assets, including spouse's share of jointly held assets.~~

120.3 ~~(e) All enrollees must pay a premium to be eligible for medical assistance under this~~
120.4 ~~subdivision, except as provided under clause (5).~~

120.5 ~~(1) An enrollee must pay the greater of a \$35 premium or the premium calculated based~~
120.6 ~~on the person's gross earned and unearned income and the applicable family size using a~~
120.7 ~~sliding fee scale established by the commissioner, which begins at one percent of income~~
120.8 ~~at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for~~
120.9 ~~those with incomes at or above 300 percent of the federal poverty guidelines.~~

120.10 ~~(2) Annual adjustments in the premium schedule based upon changes in the federal~~
120.11 ~~poverty guidelines shall be effective for premiums due in July of each year.~~

120.12 ~~(3) All enrollees who receive unearned income must pay one-half of one percent of~~
120.13 ~~unearned income in addition to the premium amount, except as provided under clause (5).~~

120.14 ~~(4)~~ (d) Increases in benefits under title II of the Social Security Act shall not be counted
120.15 as income for purposes of this subdivision until July 1 of each year.

120.16 ~~(5) Effective July 1, 2009, American Indians are exempt from paying premiums as~~
120.17 ~~required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public~~
120.18 ~~Law 111-5. For purposes of this clause, an American Indian is any person who meets the~~
120.19 ~~definition of Indian according to Code of Federal Regulations, title 42, section 447.50.~~

120.20 ~~(f)~~ (e) A person's eligibility and premium shall be determined by the local county agency.
120.21 Premiums must be paid to the commissioner. All premiums are dedicated to the
120.22 commissioner.

120.23 ~~(g) Any required premium shall be determined at application and redetermined at the~~
120.24 ~~enrollee's six-month income review or when a change in income or household size is reported.~~

120.25 (f) Enrollees must report any change in income or household size within ten days of when
120.26 the change occurs. A decreased premium resulting from a reported change in income or
120.27 household size shall be effective the first day of the next available billing month after the
120.28 change is reported. Except for changes occurring from annual cost-of-living increases, a
120.29 change resulting in an increased premium shall not affect the premium amount until the
120.30 next six-month review.

22.31 (d) For purposes of determining eligibility under this subdivision, a person's assets must
22.32 not exceed \$20,000, excluding:

23.1 (1) all assets excluded under section 256B.056;

23.2 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh
23.3 plans, and pension plans;

23.4 (3) medical expense accounts set up through the person's employer; and

23.5 (4) spousal assets, including spouse's share of jointly held assets.

23.6 (e) All enrollees must pay a premium to be eligible for medical assistance under this
23.7 subdivision, except as provided under clause (5).

23.8 (1) An enrollee must pay the greater of a \$35 premium or the premium calculated based
23.9 on the person's gross earned and unearned income and the applicable family size using a
23.10 sliding fee scale established by the commissioner, which begins at one percent of income
23.11 at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for
23.12 those with incomes at or above 300 percent of the federal poverty guidelines.

23.13 (2) Annual adjustments in the premium schedule based upon changes in the federal
23.14 poverty guidelines shall be effective for premiums due in July of each year.

23.15 (3) All enrollees who receive unearned income must pay one-half of one percent of
23.16 unearned income in addition to the premium amount, except as provided under clause (5).

23.17 (4) Increases in benefits under title II of the Social Security Act shall not be counted as
23.18 income for purposes of this subdivision until July 1 of each year.

23.19 (5) Effective July 1, 2009, American Indians are exempt from paying premiums as
23.20 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
23.21 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
23.22 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

23.23 (f) A person's eligibility and premium shall be determined by the local county agency.
23.24 Premiums must be paid to the commissioner. All premiums are dedicated to the
23.25 commissioner.

23.26 (g) Any required premium shall be determined at application and redetermined at the
23.27 enrollee's six-month income review or when a change in income or household size is reported.
23.28 Enrollees must report any change in income or household size within ten days of when the
23.29 change occurs. A decreased premium resulting from a reported change in income or
23.30 household size shall be effective the first day of the next available billing month after the
23.31 change is reported. Except for changes occurring from annual cost-of-living increases, a
24.1 change resulting in an increased premium shall not affect the premium amount until the
24.2 next six-month review.

120.31 ~~(h) Premium payment is due upon notification from the commissioner of the premium~~
 120.32 ~~amount required. Premiums may be paid in installments at the discretion of the commissioner.~~

121.1 ~~(i) Nonpayment of the premium shall result in denial or termination of medical assistance~~
 121.2 ~~unless the person demonstrates good cause for nonpayment. "Good cause" means an excuse~~
 121.3 ~~for the enrollee's failure to pay the required premium when due because the circumstances~~
 121.4 ~~were beyond the enrollee's control or not reasonably foreseeable. The commissioner shall~~
 121.5 ~~determine whether good cause exists based on the weight of the supporting evidence~~
 121.6 ~~submitted by the enrollee to demonstrate good cause. Except when an installment agreement~~
 121.7 ~~is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must~~
 121.8 ~~pay any past due premiums as well as current premiums due prior to being reenrolled.~~
 121.9 ~~Nonpayment shall include payment with a returned, refused, or dishonored instrument. The~~
 121.10 ~~commissioner may require a guaranteed form of payment as the only means to replace a~~
 121.11 ~~returned, refused, or dishonored instrument.~~

121.12 ~~(j) (g) The commissioner is authorized to determine that a premium amount was calculated~~
 121.13 ~~or billed in error, make corrections to financial records and billing systems, and refund~~
 121.14 ~~premiums collected in error.~~

121.15 ~~(h) For enrollees whose income does not exceed 200 percent of the federal poverty~~
 121.16 ~~guidelines who are: (1) eligible under this subdivision and who are also enrolled in Medicare;~~
 121.17 ~~and (2) not eligible for medical assistance reimbursement of Medicare premiums under~~
 121.18 ~~subdivisions 3, 3a, 3b, or 4, the commissioner shall reimburse the enrollee for Medicare~~
 121.19 ~~part A and Medicare part B premiums under section 256B.0625, subdivision 15, paragraph~~
 121.20 ~~(a), and part A and part B coinsurance and deductibles. Reimbursement of the Medicare~~
 121.21 ~~coinsurance and deductibles, when added to the amount paid by Medicare, must not exceed~~
 121.22 ~~the total rate the provider would have received for the same service or services if the person~~
 121.23 ~~was receiving benefits as a qualified Medicare beneficiary.~~

121.24 ~~(i) The commissioner must permit any individual who was disenrolled for nonpayment~~
 121.25 ~~of premiums previously required under this subdivision to reapply for medical assistance~~
 121.26 ~~under this subdivision and be reenrolled if eligible without paying past due premiums.~~

121.27 EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval,
 121.28 whichever occurs later. The commissioner of human services shall notify the revisor of
 121.29 statutes when federal approval is obtained.

121.30 Sec. 5. Minnesota Statutes 2022, section 256B.0625, subdivision 17, is amended to read:

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

122.1 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
 122.2 emergency medical care or transportation costs incurred by eligible persons in obtaining
 122.3 emergency or nonemergency medical care when paid directly to an ambulance company,

24.3 (h) Premium payment is due upon notification from the commissioner of the premium
 24.4 amount required. Premiums may be paid in installments at the discretion of the commissioner.

24.5 (i) Nonpayment of the premium shall result in denial or termination of medical assistance
 24.6 unless the person demonstrates good cause for nonpayment. "Good cause" means an excuse
 24.7 for the enrollee's failure to pay the required premium when due because the circumstances
 24.8 were beyond the enrollee's control or not reasonably foreseeable. The commissioner shall
 24.9 determine whether good cause exists based on the weight of the supporting evidence
 24.10 submitted by the enrollee to demonstrate good cause. Except when an installment agreement
 24.11 is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must
 24.12 pay any past due premiums as well as current premiums due prior to being reenrolled.
 24.13 Nonpayment shall include payment with a returned, refused, or dishonored instrument. The
 24.14 commissioner may require a guaranteed form of payment as the only means to replace a
 24.15 returned, refused, or dishonored instrument.

24.16 (j) The commissioner is authorized to determine that a premium amount was calculated
 24.17 or billed in error, make corrections to financial records and billing systems, and refund
 24.18 premiums collected in error.

24.19 ~~(j) (k)~~ For enrollees whose income does not exceed 200 percent of the federal poverty
 24.20 guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the
 24.21 enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph
 24.22 (a).

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

- 122.4 nonemergency medical transportation company, or other recognized providers of
122.5 transportation services. Medical transportation must be provided by:
- 122.6 (1) nonemergency medical transportation providers who meet the requirements of this
122.7 subdivision;
- 122.8 (2) ambulances, as defined in section 144E.001, subdivision 2;
- 122.9 (3) taxicabs that meet the requirements of this subdivision;
- 122.10 (4) public transit, as defined in section 174.22, subdivision 7; or
- 122.11 (5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472,
122.12 subdivision 1, paragraph (h).
- 122.13 (c) Medical assistance covers nonemergency medical transportation provided by
122.14 nonemergency medical transportation providers enrolled in the Minnesota health care
122.15 programs. All nonemergency medical transportation providers must comply with the
122.16 operating standards for special transportation service as defined in sections 174.29 to 174.30
122.17 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
122.18 commissioner and reported on the claim as the individual who provided the service. All
122.19 nonemergency medical transportation providers shall bill for nonemergency medical
122.20 transportation services in accordance with Minnesota health care programs criteria. Publicly
122.21 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
122.22 requirements outlined in this paragraph.
- 122.23 (d) An organization may be terminated, denied, or suspended from enrollment if:
- 122.24 (1) the provider has not initiated background studies on the individuals specified in
122.25 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or
- 122.26 (2) the provider has initiated background studies on the individuals specified in section
122.27 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:
- 122.28 (i) the commissioner has sent the provider a notice that the individual has been
122.29 disqualified under section 245C.14; and
- 122.30 (ii) the individual has not received a disqualification set-aside specific to the special
122.31 transportation services provider under sections 245C.22 and 245C.23.
- 122.32 (e) The administrative agency of nonemergency medical transportation must:
- 123.1 (1) adhere to the policies defined by the commissioner;
- 123.2 (2) pay nonemergency medical transportation providers for services provided to
123.3 Minnesota health care programs beneficiaries to obtain covered medical services;
- 123.4 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
123.5 trips, and number of trips by mode; and

123.6 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
123.7 administrative structure assessment tool that meets the technical requirements established
123.8 by the commissioner, reconciles trip information with claims being submitted by providers,
123.9 and ensures prompt payment for nonemergency medical transportation services.

123.10 (f) Until the commissioner implements the single administrative structure and delivery
123.11 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
123.12 commissioner or an entity approved by the commissioner that does not dispatch rides for
123.13 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

123.14 (g) The commissioner may use an order by the recipient's attending physician, advanced
123.15 practice registered nurse, physician assistant, or a medical or mental health professional to
123.16 certify that the recipient requires nonemergency medical transportation services.
123.17 Nonemergency medical transportation providers shall perform driver-assisted services for
123.18 eligible individuals, when appropriate. Driver-assisted service includes passenger pickup
123.19 at and return to the individual's residence or place of business, assistance with admittance
123.20 of the individual to the medical facility, and assistance in passenger securement or in securing
123.21 of wheelchairs, child seats, or stretchers in the vehicle.

123.22 Nonemergency medical transportation providers must take clients to the health care
123.23 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
123.24 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
123.25 authorization from the local agency.

123.26 Nonemergency medical transportation providers may not bill for separate base rates for
123.27 the continuation of a trip beyond the original destination. Nonemergency medical
123.28 transportation providers must maintain trip logs, which include pickup and drop-off times,
123.29 signed by the medical provider or client, whichever is deemed most appropriate, attesting
123.30 to mileage traveled to obtain covered medical services. Clients requesting client mileage
123.31 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
123.32 services.

124.1 (h) The administrative agency shall use the level of service process established by the
124.2 commissioner to determine the client's most appropriate mode of transportation. If public
124.3 transit or a certified transportation provider is not available to provide the appropriate service
124.4 mode for the client, the client may receive a onetime service upgrade.

124.5 (i) The covered modes of transportation are:

124.6 (1) client reimbursement, which includes client mileage reimbursement provided to
124.7 clients who have their own transportation, or to family or an acquaintance who provides
124.8 transportation to the client;

124.9 (2) volunteer transport, which includes transportation by volunteers using their own
124.10 vehicle;

- 124.11 (3) unassisted transport, which includes transportation provided to a client by a taxicab
124.12 or public transit. If a taxicab or public transit is not available, the client can receive
124.13 transportation from another nonemergency medical transportation provider;
- 124.14 (4) assisted transport, which includes transport provided to clients who require assistance
124.15 by a nonemergency medical transportation provider;
- 124.16 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
124.17 dependent on a device and requires a nonemergency medical transportation provider with
124.18 a vehicle containing a lift or ramp;
- 124.19 (6) protected transport, which includes transport provided to a client who has received
124.20 a prescreening that has deemed other forms of transportation inappropriate and who requires
124.21 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
124.22 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
124.23 the vehicle driver; and (ii) who is certified as a protected transport provider; and
- 124.24 (7) stretcher transport, which includes transport for a client in a prone or supine position
124.25 and requires a nonemergency medical transportation provider with a vehicle that can transport
124.26 a client in a prone or supine position.
- 124.27 (j) The local agency shall be the single administrative agency and shall administer and
124.28 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the
124.29 commissioner has developed, made available, and funded the web-based single administrative
124.30 structure, assessment tool, and level of need assessment under subdivision 18e. The local
124.31 agency's financial obligation is limited to funds provided by the state or federal government.
- 124.32 (k) The commissioner shall:
- 125.1 (1) verify that the mode and use of nonemergency medical transportation is appropriate;
- 125.2 (2) verify that the client is going to an approved medical appointment; and
- 125.3 (3) investigate all complaints and appeals.
- 125.4 (l) The administrative agency shall pay for the services provided in this subdivision and
125.5 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,
125.6 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
125.7 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.
- 125.8 (m) Payments for nonemergency medical transportation must be paid based on the client's
125.9 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
125.10 medical assistance reimbursement rates for nonemergency medical transportation services
125.11 that are payable by or on behalf of the commissioner for nonemergency medical
125.12 transportation services are:
- 125.13 (1) \$0.22 per mile for client reimbursement;

125.14 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
125.15 transport;

125.16 (3) equivalent to the standard fare for unassisted transport when provided by public
125.17 transit, and ~~\$11~~ \$12.93 for the base rate and ~~\$1.30~~ \$1.53 per mile when provided by a
125.18 nonemergency medical transportation provider;

125.19 (4) ~~\$13~~ \$15.28 for the base rate and ~~\$1.30~~ \$1.53 per mile for assisted transport;

125.20 (5) ~~\$18~~ \$21.15 for the base rate and ~~\$1.55~~ \$1.82 per mile for lift-equipped/ramp transport;

125.21 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

125.22 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
125.23 an additional attendant if deemed medically necessary.

125.24 (n) The base rate for nonemergency medical transportation services in areas defined
125.25 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
125.26 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
125.27 services in areas defined under RUCA to be rural or super rural areas is:

125.28 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
125.29 rate in paragraph (m), clauses (1) to (7); and

125.30 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
125.31 rate in paragraph (m), clauses (1) to (7).

126.1 (o) For purposes of reimbursement rates for nonemergency medical transportation
126.2 services under paragraphs (m) and (n), the zip code of the recipient's place of residence
126.3 shall determine whether the urban, rural, or super rural reimbursement rate applies.

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

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

126.10 (r) Effective for the first day of each calendar quarter in which the price of gasoline as
126.11 posted publicly by the United States Energy Information Administration exceeds \$3.00 per
126.12 gallon, the commissioner shall adjust the rate paid per mile in paragraph (m) by one percent
126.13 up or down for every increase or decrease of ten cents for the price of gasoline. The increase
126.14 or decrease must be calculated using a base gasoline price of \$3.00. The percentage increase
126.15 or decrease must be calculated using the average of the most recently available price of all
126.16 grades of gasoline for Minnesota as posted publicly by the United States Energy Information
126.17 Administration.

126.18 **EFFECTIVE DATE.** This section is effective January 1, 2024, or upon federal approval,
126.19 whichever is later. The commissioner of human services shall notify the revisor of statutes
126.20 when federal approval is obtained.

126.21 Sec. 6. Minnesota Statutes 2022, section 256B.0625, subdivision 17a, is amended to read:

126.22 Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance
126.23 services. Providers shall bill ambulance services according to Medicare criteria.
126.24 Nonemergency ambulance services shall not be paid as emergencies. Effective for services
126.25 rendered on or after July 1, 2001, medical assistance payments for ambulance services shall
126.26 be paid at the Medicare reimbursement rate or at the medical assistance payment rate in
126.27 effect on July 1, 2000, whichever is greater.

126.28 (b) Effective for services provided on or after July 1, 2016, medical assistance payment
126.29 rates for ambulance services identified in this paragraph are increased by five percent.
126.30 Capitation payments made to managed care plans and county-based purchasing plans for
126.31 ambulance services provided on or after January 1, 2017, shall be increased to reflect this
126.32 rate increase. The increased rate described in this paragraph applies to ambulance service
126.33 providers whose base of operations as defined in section 144E.10 is located:

127.1 (1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside
127.2 the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

127.3 (2) within a municipality with a population of less than 1,000.

127.4 (c) Effective for the first day of each calendar quarter in which the price of gasoline as
127.5 posted publicly by the United States Energy Information Administration exceeds \$3.00 per
127.6 gallon, the commissioner shall adjust the rate paid per mile in paragraphs (a) and (b) by one
127.7 percent up or down for every increase or decrease of ten cents for the price of gasoline. The
127.8 increase or decrease must be calculated using a base gasoline price of \$3.00. The percentage
127.9 increase or decrease must be calculated using the average of the most recently available
127.10 price of all grades of gasoline for Minnesota as posted publicly by the United States Energy
127.11 Information Administration.

127.12 **EFFECTIVE DATE.** This section is effective January 1, 2024, or upon federal approval,
127.13 whichever is later. The commissioner of human services shall notify the revisor of statutes
127.14 when federal approval is obtained.

127.15 Sec. 7. Minnesota Statutes 2022, section 256B.0625, subdivision 18h, is amended to read:

127.16 Subd. 18h. **Nonemergency medical transportation provisions related to managed**
127.17 **care.** (a) The following nonemergency medical transportation (NEMT) subdivisions apply
127.18 to managed care plans and county-based purchasing plans:

127.19 (1) subdivision 17, paragraphs (a), (b), (i), and (n);

127.20 (2) subdivision 18; and

127.21 (3) subdivision 18a.

127.22 (b) A nonemergency medical transportation provider must comply with the operating
127.23 standards for special transportation service specified in sections 174.29 to 174.30 and
127.24 Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire
127.25 vehicles are exempt from the requirements in this paragraph.

127.26 (c) Managed care plans and county-based purchasing plans must provide a fuel adjustment
127.27 for NEMT rates when fuel exceeds \$3 per gallon. If, for any contract year, federal approval
127.28 is not received for this paragraph, the commissioner must adjust the capitation rates paid to
127.29 managed care plans and county-based purchasing plans for that contract year to reflect the
127.30 removal of this provision. Contracts between managed care plans and county-based
127.31 purchasing plans and providers to whom this paragraph applies must allow recovery of
127.32 payments from those providers if capitation rates are adjusted in accordance with this
128.1 paragraph. Payment recoveries must not exceed the amount equal to any increase in rates
128.2 that results from this paragraph. This paragraph expires if federal approval is not received
128.3 for this paragraph at any time.

128.4 **EFFECTIVE DATE.** This section is effective January 1, 2024.

128.5 Sec. 8. Minnesota Statutes 2022, section 256B.0625, subdivision 22, is amended to read:

128.6 Subd. 22. **Hospice care.** Medical assistance covers hospice care services under Public
128.7 Law 99-272, section 9505, to the extent authorized by rule, except that a recipient age 21
128.8 or under who elects to receive hospice services does not waive coverage for services that
128.9 are related to the treatment of the condition for which a diagnosis of terminal illness has
128.10 been made. Hospice respite and end-of-life care under subdivision 22a are not hospice care
128.11 services under this subdivision.

128.12 **EFFECTIVE DATE.** This section is effective January 1, 2024.

128.13 Sec. 9. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
128.14 to read:

128.15 Subd. 22a. **Residential hospice facility; hospice respite and end-of-life care for**
128.16 **children.** (a) Medical assistance covers hospice respite and end-of-life care if the care is
128.17 for recipients age 21 or under who elect to receive hospice care delivered in a facility that
128.18 is licensed under sections 144A.75 to 144A.755 and that is a residential hospice facility
128.19 under section 144A.75, subdivision 13, paragraph (a). Hospice care services under
128.20 subdivision 22 are not hospice respite or end-of-life care under this subdivision.

128.21 (b) The payment rates for coverage under this subdivision must be 100 percent of the
128.22 Medicare rate for continuous home care hospice services as published in the Centers for
128.23 Medicare and Medicaid Services annual final rule updating payments and policies for hospice
128.24 care. Payment for hospice respite and end-of-life care under this subdivision must be made
128.25 from state money, though the commissioner must seek to obtain federal financial participation
128.26 for the payments. Payment for hospice respite and end-of-life care must be paid to the

128.27 residential hospice facility and are not included in any limit or cap amount applicable to
128.28 hospice services payments to the elected hospice services provider.

128.29 (c) Certification of the residential hospice facility by the federal Medicare program must
128.30 not be a requirement of medical assistance payment for hospice respite and end-of-life care
128.31 under this subdivision.

128.32 **EFFECTIVE DATE.** This section is effective January 1, 2024.

129.1 Sec. 10. Minnesota Statutes 2022, section 256B.073, subdivision 3, is amended to read:

129.2 Subd. 3. **Requirements.** (a) In developing implementation requirements for electronic
129.3 visit verification, the commissioner shall ensure that the requirements:

129.4 (1) are minimally administratively and financially burdensome to a provider;

129.5 (2) are minimally burdensome to the service recipient and the least disruptive to the
129.6 service recipient in receiving and maintaining allowed services;

129.7 (3) consider existing best practices and use of electronic visit verification;

129.8 (4) are conducted according to all state and federal laws;

129.9 (5) are effective methods for preventing fraud when balanced against the requirements
129.10 of clauses (1) and (2); and

129.11 (6) are consistent with the Department of Human Services' policies related to covered
129.12 services, flexibility of service use, and quality assurance.

129.13 (b) The commissioner shall make training available to providers on the electronic visit
129.14 verification system requirements.

129.15 (c) The commissioner shall establish baseline measurements related to preventing fraud
129.16 and establish measures to determine the effect of electronic visit verification requirements
129.17 on program integrity.

129.18 (d) The commissioner shall make a state-selected electronic visit verification system
129.19 available to providers of services.

129.20 (e) The commissioner shall make available and publish on the agency website the name
129.21 and contact information for the vendor of the state-selected electronic visit verification
129.22 system and the other vendors that offer alternative electronic visit verification systems. The
129.23 information provided must state that the state-selected electronic visit verification system
129.24 is offered at no cost to the provider of services and that the provider may choose an alternative
129.25 system that may be at a cost to the provider.

129.26 Sec. 11. Minnesota Statutes 2022, section 256B.073, is amended by adding a subdivision
129.27 to read:

129.28 Subd. 5. **Vendor requirements.** (a) The vendor of the electronic visit verification system
129.29 selected by the commissioner and the vendor's affiliate must comply with the requirements
129.30 of this subdivision.

130.1 (b) The vendor of the state-selected electronic visit verification system and the vendor's
130.2 affiliate must:

130.3 (1) notify the provider of services that the provider may choose the state-selected
130.4 electronic visit verification system at no cost to the provider;

130.5 (2) offer the state-selected electronic visit verification system to the provider of services
130.6 prior to offering any fee-based electronic visit verification system;

130.7 (3) notify the provider of services that the provider may choose any fee-based electronic
130.8 visit verification system prior to offering the vendor's or its affiliate's fee-based electronic
130.9 visit verification system;

130.10 (4) when offering the state-selected electronic visit verification system, clearly
130.11 differentiate between the state-selected electronic visit verification system and the vendor's
130.12 or its affiliate's alternative fee-based system; and

130.13 (5) allow the provider of services, at no cost to the provider, to terminate the agreement
130.14 after 12 months of the provider executing the agreement.

130.15 (c) The vendor of the state-selected electronic visit verification system and the vendor's
130.16 affiliate must not use state data that is not available to other vendors of electronic visit
130.17 verification systems to develop, promote, or sell the vendor's or its affiliate's alternative
130.18 electronic visit verification system.

130.19 (d) Upon request from the provider, the vendor of the state-selected electronic visit
130.20 verification system must provide proof of compliance with the requirements of this
130.21 subdivision.

130.22 (e) An agreement between the vendor of the state-selected electronic visit verification
130.23 system or its affiliate and a provider of services for an electronic visit verification system
130.24 that is not the state-selected system entered into on or after July 1, 2023, is subject to
130.25 immediate termination by the provider if the vendor violates any of the requirements of this
130.26 subdivision.

130.27 **EFFECTIVE DATE.** This section is effective July 1, 2023.

130.28 Sec. 12. Minnesota Statutes 2022, section 256B.14, subdivision 2, is amended to read:

130.29 Subd. 2. **Actions to obtain payment.** The state agency shall promulgate rules to
130.30 determine the ability of responsible relatives to contribute partial or complete payment or
130.31 repayment of medical assistance furnished to recipients for whom they are responsible. All

130.32 medical assistance exclusions shall be allowed, and a resource limit of \$10,000 for
131.1 nonexcluded resources shall be implemented. Above these limits, a contribution of one-third
131.2 of the excess resources shall be required. These rules shall not require payment or repayment
131.3 when payment would cause undue hardship to the responsible relative or that relative's
131.4 immediate family. These rules ~~shall be consistent with the requirements of section 252.27~~
131.5 ~~for~~ do not apply to parents of children whose eligibility for medical assistance was determined
131.6 without deeming of the parents' resources and income under the Tax Equity and Fiscal
131.7 Responsibility Act (TEFRA) option or to parents of children accessing home and
131.8 community-based waiver services. The county agency shall give the responsible relative
131.9 notice of the amount of the payment or repayment. If the state agency or county agency
131.10 finds that notice of the payment obligation was given to the responsible relative, but that
131.11 the relative failed or refused to pay, a cause of action exists against the responsible relative
131.12 for that portion of medical assistance granted after notice was given to the responsible
131.13 relative, which the relative was determined to be able to pay.

131.14 The action may be brought by the state agency or the county agency in the county where
131.15 assistance was granted, for the assistance, together with the costs of disbursements incurred
131.16 due to the action.

131.17 In addition to granting the county or state agency a money judgment, the court may,
131.18 upon a motion or order to show cause, order continuing contributions by a responsible
131.19 relative found able to repay the county or state agency. The order shall be effective only
131.20 for the period of time during which the recipient receives medical assistance from the county
131.21 or state agency.

131.22 Sec. 13. Minnesota Statutes 2022, section 256B.766, is amended to read:

131.23 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

131.24 (a) Effective for services provided on or after July 1, 2009, total payments for basic care
131.25 services, shall be reduced by three percent, except that for the period July 1, 2009, through
131.26 June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance
131.27 and general assistance medical care programs, prior to third-party liability and spenddown
131.28 calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services,
131.29 occupational therapy services, and speech-language pathology and related services as basic
131.30 care services. The reduction in this paragraph shall apply to physical therapy services,
131.31 occupational therapy services, and speech-language pathology and related services provided
131.32 on or after July 1, 2010.

131.33 (b) Payments made to managed care plans and county-based purchasing plans shall be
131.34 reduced for services provided on or after October 1, 2009, to reflect the reduction effective
132.1 July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010,
132.2 to reflect the reduction effective July 1, 2010.

132.3 (c) Effective for services provided on or after September 1, 2011, through June 30, 2013,
132.4 total payments for outpatient hospital facility fees shall be reduced by five percent from the
132.5 rates in effect on August 31, 2011.

132.6 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,
132.7 total payments for ambulatory surgery centers facility fees, medical supplies and durable
132.8 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,
132.9 renal dialysis services, laboratory services, public health nursing services, physical therapy
132.10 services, occupational therapy services, speech therapy services, eyeglasses not subject to
132.11 a volume purchase contract, hearing aids not subject to a volume purchase contract, and
132.12 anesthesia services shall be reduced by three percent from the rates in effect on August 31,
132.13 2011.

132.14 (e) Effective for services provided on or after September 1, 2014, payments for
132.15 ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory
132.16 services, public health nursing services, eyeglasses not subject to a volume purchase contract,
132.17 and hearing aids not subject to a volume purchase contract shall be increased by three percent
132.18 and payments for outpatient hospital facility fees shall be increased by three percent.
132.19 Payments made to managed care plans and county-based purchasing plans shall not be
132.20 adjusted to reflect payments under this paragraph.

132.21 (f) Payments for medical supplies and durable medical equipment not subject to a volume
132.22 purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through
132.23 June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable
132.24 medical equipment not subject to a volume purchase contract, and prosthetics and orthotics,
132.25 provided on or after July 1, 2015, shall be increased by three percent from the rates as
132.26 determined under paragraphs (i) and (j).

132.27 (g) Effective for services provided on or after July 1, 2015, payments for outpatient
132.28 hospital facility fees, medical supplies and durable medical equipment not subject to a
132.29 volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified
132.30 in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent
132.31 from the rates in effect on June 30, 2015. Payments made to managed care plans and
132.32 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

132.33 (h) This section does not apply to physician and professional services, inpatient hospital
132.34 services, family planning services, mental health services, dental services, prescription
133.1 drugs, medical transportation, federally qualified health centers, rural health centers, Indian
133.2 health services, and Medicare cost-sharing.

133.3 (i) Effective for services provided on or after July 1, 2015, the following categories of
133.4 medical supplies and durable medical equipment shall be individually priced items: ~~enteral~~
133.5 ~~nutrition and supplies~~, customized and other specialized tracheostomy tubes and supplies,
133.6 electric patient lifts, and durable medical equipment repair and service. This paragraph does
133.7 not apply to medical supplies and durable medical equipment subject to a volume purchase
133.8 contract, products subject to the preferred diabetic testing supply program, and items provided

133.9 to dually eligible recipients when Medicare is the primary payer for the item. The
133.10 commissioner shall not apply any medical assistance rate reductions to durable medical
133.11 equipment as a result of Medicare competitive bidding.

133.12 (j) Effective for services provided on or after July 1, 2015, medical assistance payment
133.13 rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased
133.14 as follows:

133.15 (1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that
133.16 were subject to the Medicare competitive bid that took effect in January of 2009 shall be
133.17 increased by 9.5 percent; and

133.18 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on
133.19 the medical assistance fee schedule, whether or not subject to the Medicare competitive bid
133.20 that took effect in January of 2009, shall be increased by 2.94 percent, with this increase
133.21 being applied after calculation of any increased payment rate under clause (1).

133.22 This paragraph does not apply to medical supplies and durable medical equipment subject
133.23 to a volume purchase contract, products subject to the preferred diabetic testing supply
133.24 program, items provided to dually eligible recipients when Medicare is the primary payer
133.25 for the item, and individually priced items identified in paragraph (i). Payments made to
133.26 managed care plans and county-based purchasing plans shall not be adjusted to reflect the
133.27 rate increases in this paragraph.

133.28 (k) Effective for nonpressure support ventilators provided on or after January 1, 2016,
133.29 the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective
133.30 for pressure support ventilators provided on or after January 1, 2016, the rate shall be the
133.31 lower of the submitted charge or 47 percent above the Medicare fee schedule rate. For
133.32 payments made in accordance with this paragraph, if, and to the extent that, the commissioner
133.33 identifies that the state has received federal financial participation for ventilators in excess
133.34 of the amount allowed effective January 1, 2018, under United States Code, title 42, section
134.1 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and
134.2 Medicaid Services with state funds and maintain the full payment rate under this paragraph.

134.3 (l) Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that
134.4 are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social
134.5 Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall
134.6 not be applied to the items listed in this paragraph.

134.7 (m) For dates of service on or after July 1, 2023, through June 30, 2024, enteral nutrition
134.8 and supplies must be paid according to this paragraph. If sufficient data exists for a product
134.9 or supply, payment must be based upon the 50th percentile of the usual and customary
134.10 charges per product code submitted to the department, using only charges submitted per
134.11 unit. Increases in rates resulting from the 50th percentile payment method must not exceed
134.12 150 percent of the previous fiscal year's rate per code and product combination. Data are
134.13 sufficient if: (1) the department has at least 100 paid claim lines by at least ten different

134.14 providers for a given product or supply; or (2) in the absence of the data in clause (1), the
134.15 department has at least 20 claim lines by at least five different providers for a product or
134.16 supply that does not meet the requirements of clause (1). If sufficient data are not available
134.17 to calculate the 50th percentile for enteral products or supplies, the payment rate shall be
134.18 the payment rate in effect on June 30, 2023.

134.19 (n) For dates of service on or after July 1, 2024, enteral nutrition and supplies must be
134.20 paid according to this paragraph and updated annually each January 1. If sufficient data
134.21 exists for a product or supply, payment must be based upon the 50th percentile of the usual
134.22 and customary charges per product code submitted to the department for the previous
134.23 calendar year, using only charges submitted per unit. Increases in rates resulting from the
134.24 50th percentile payment method must not exceed 150 percent of the previous year's rate per
134.25 code and product combination. Data are sufficient if: (1) the department has at least 100
134.26 paid claim lines by at least ten different providers for a given product or supply; or (2) in
134.27 the absence of the data in clause (1), the department has at least 20 claim lines by at least
134.28 five different providers for a product or supply that does not meet the requirements of clause
134.29 (1). If sufficient data is not available to calculate the 50th percentile for enteral products or
134.30 supplies, the payment shall be the manufacturer's suggested retail price of that product or
134.31 supply minus 20 percent. If the manufacturer's suggested retail price is not available, payment
134.32 shall be the actual acquisition cost of that product or supply plus 20 percent.

135.1 Sec. 14. **INCREASED MEDICAL ASSISTANCE INCOME LIMIT FOR OLDER**
135.2 **ADULTS AND PERSONS WITH DISABILITIES.**

135.3 Effective July 1, 2023, the commissioner of human services must increase the income
135.4 limit under Minnesota Statutes, section 256B.056, subdivision 4, paragraph (a), to a level
135.5 that is projected to result in a net cost to the state of \$5,000,000 for the 2026-2027 biennium.