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ARTICLE 1

HEALTH CARE

Section 1. Minnesota Statutes 2022, section 256.01, is amended by adding a subdivision to read:

Subd. 43. **Education on contraceptive options.** The commissioner shall require hospitals and primary care providers serving medical assistance and MinnesotaCare enrollees to develop and implement protocols to provide enrollees, when appropriate, with comprehensive and scientifically accurate information on the full range of contraceptive options, in a medically ethical, culturally competent, and noncoercive manner. The information provided must be designed to assist enrollees in identifying the contraceptive method that best meets their needs and the needs of their families. The protocol must specify the enrollee categories to which this requirement will be applied, the process to be used, and the information and resources to be provided. Hospitals and providers must make this protocol available to the commissioner upon request.

Sec. 2. Minnesota Statutes 2022, section 256.0471, subdivision 1, is amended to read:

Subdivision 1. **Qualifying overpayment.** Any overpayment for assistance granted under ~~chapter 119B,~~ the MFIP program formerly codified under sections 256.031 to 256.0361~~;~~ and the AFDC program formerly codified under sections 256.72 to 256.871; for assistance granted under chapters ~~256B for state-funded medical assistance~~ 119B, 256D, 256I, 256J, and 256K~~, and 256L~~; for assistance granted pursuant to section 256.045, subdivision 10, for state-funded medical assistance and state-funded MinnesotaCare under chapters 256B and 256L; and for assistance granted under the Supplemental Nutrition Assistance Program (SNAP), except agency error claims, become a judgment by operation of law 90 days after the notice of overpayment is personally served upon the recipient in a manner that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts, or by certified mail, return receipt requested. This judgment shall be entitled to full faith and credit in this and any other state.

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

Sec. 3. Minnesota Statutes 2022, section 256.9655, is amended by adding a subdivision to read:

Subd. 3. **Prompt payment required.** (a) In paying claims under medical assistance, the commissioner shall comply with Code of Federal Regulations, title 42, section 447.45.

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ARTICLE 1

DEPARTMENT OF HUMAN SERVICES HEALTH CARE

UES2995-2, ARTICLE 1, SECTION 1, HAS BEEN MOVED OUT TO MATCH S2995-3, ARTICLE 2, SECTION 3.

UES2995-2, ARTICLE 1, SECTION 2, HAS BEEN MOVED OUT TO MATCH S2995-3, ARTICLE 2, SECTION 8.

Sec. 3. Minnesota Statutes 2022, section 256.01, is amended by adding a subdivision to read:

Subd. 43. **Education on contraceptive options.** The commissioner shall require hospitals and primary care providers serving medical assistance and MinnesotaCare enrollees to develop and implement protocols to provide enrollees, when appropriate, with comprehensive and scientifically accurate information on the full range of contraceptive options, in a medically ethical, culturally competent, and noncoercive manner. The information provided must be designed to assist enrollees in identifying the contraceptive method that best meets the enrollees' needs and the needs of the enrollees' families. The protocol must specify the enrollee categories to which this requirement will be applied, the process to be used, and the information and resources to be provided. Hospitals and providers must make this protocol available to the commissioner upon request.

Sec. 4. Minnesota Statutes 2022, section 256.0471, subdivision 1, is amended to read:

Subdivision 1. **Qualifying overpayment.** Any overpayment for assistance granted under ~~chapter 119B,~~ the MFIP program formerly codified under sections 256.031 to 256.0361~~;~~ ~~and~~ the AFDC program formerly codified under sections 256.72 to 256.871; for assistance granted under chapters ~~256B for state-funded medical assistance,~~119B, 256D, 256I, 256J, and 256K~~, and 256L~~; for assistance granted pursuant to section 256.045, subdivision 10, for state-funded medical assistance and state-funded MinnesotaCare under chapters 256B and 256L; and for assistance granted under the Supplemental Nutrition Assistance Program (SNAP), except agency error claims, become a judgment by operation of law 90 days after the notice of overpayment is personally served upon the recipient in a manner that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts, or by certified mail, return receipt requested. This judgment shall be entitled to full faith and credit in this and any other state.

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

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(b) If the commissioner does not pay or deny a clean claim within the period provided in paragraph (a), the commissioner must pay interest on the claim for the period beginning on the day after the required payment date specified in paragraph (a) and ending on the date on which the commissioner makes the payment or denies the claim.

(c) The rate of interest paid by the commissioner under this subdivision shall be 1.5 percent per month or any part of a month.

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

Sec. 4. Minnesota Statutes 2022, 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

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Sec. 5. Minnesota Statutes 2022, 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

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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

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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

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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. 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;

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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;

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(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) Effective for discharges occurring on or after July 1, 2023, payment rates under this section must be rebased to reflect those changes in hospital costs between the existing base year or years and one year prior to the rate year. 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 must 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 the base year or years and one year prior to the rate year must be measured using the hospital cost index defined in subdivision 1, paragraph (a). The commissioner must establish the base year for each rebasing period considering the most recent year or years for which filed Medicare cost reports are available. 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 the differential in payment rates compared to the individual hospital's costs by hospital.

(k) Effective for discharges occurring on or after July 1, 2023, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area must be a rate equal to 100 percent of their base year costs inflated to the year prior to the rate year using the hospital cost index defined in subdivision 1, paragraph (a).

(l) 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

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(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

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(6) geographic location.

Sec. 5. Minnesota Statutes 2022, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) Certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

(c) Upon federal approval of the related state plan amendment, paragraph (b) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

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(6) geographic location.

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

S2995-3, ARTICLE 1, SECTION 5, MATCHES BOTH UES2995-2, ARTICLE 1, SECTION 6, AND ARTICLE 2, SECTION 11. UES2995-2, ARTICLE 2, SECTION 11, WAS MOVED IN FROM THE ARTICLE 2 SIDE-BY-SIDE TO THE ARTICLE 1 SIDE-BY-SIDE AND APPEARS IMMEDIATELY AFTER UES2995-2, ARTICLE 1, SECTION 6

Sec. 6. Minnesota Statutes 2022, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) Certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

(c) Upon federal approval of the related state plan amendment, paragraph (b) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

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(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology using 2012 as the base year. Annual payments made under this paragraph shall equal the total amount of payments made for 2012. A licensed children's hospital shall receive only a single DSH factor for children's hospitals. Other DSH factors may be combined to arrive at a single factor for each hospital that is eligible for DSH payments. The new methodology shall make payments only to hospitals located in Minnesota and include the following factors:

(1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000 fee-for-service discharges in the base year shall receive a factor of 0.7880;

(2) a hospital that has in effect for the initial rate year a contract with the commissioner to provide extended psychiatric inpatient services under section 256.9693 shall receive a factor of 0.0160;

(3) a hospital that has received medical assistance payment for at least 20 transplant services in the base year shall receive a factor of 0.0435;

(4) a hospital that has a medical assistance utilization rate in the base year between 20 percent up to one standard deviation above the statewide mean utilization rate shall receive a factor of 0.0468;

(5) a hospital that has a medical assistance utilization rate in the base year that is at least one standard deviation above the statewide mean utilization rate but is less than two and one-half standard deviations above the mean shall receive a factor of 0.2300; and

(6) a hospital that is a level one trauma center and that has a medical assistance utilization rate in the base year that is at least two and ~~one-half~~ one-quarter standard deviations above the statewide mean utilization rate shall receive a factor of 0.3711.

(e) For the purposes of determining eligibility for the disproportionate share hospital factors in paragraph (d), clauses (1) to (6), the medical assistance utilization rate and discharge thresholds shall be measured using only one year when a two-year base period is used.

(f) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

(g) An additional payment adjustment shall be established by the commissioner under this subdivision for a hospital that provides high levels of administering high-cost drugs to

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(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology using 2012 as the base year. Annual payments made under this paragraph shall equal the total amount of payments made for 2012. A licensed children's hospital shall receive only a single DSH factor for children's hospitals. Other DSH factors may be combined to arrive at a single factor for each hospital that is eligible for DSH payments. The new methodology shall make payments only to hospitals located in Minnesota and include the following factors:

(1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000 fee-for-service discharges in the base year shall receive a factor of 0.7880;

(2) a hospital that has in effect for the initial rate year a contract with the commissioner to provide extended psychiatric inpatient services under section 256.9693 shall receive a factor of 0.0160;

(3) a hospital that has received medical assistance payment for at least 20 transplant services in the base year shall receive a factor of 0.0435;

(4) a hospital that has a medical assistance utilization rate in the base year between 20 percent up to one standard deviation above the statewide mean utilization rate shall receive a factor of 0.0468;

(5) a hospital that has a medical assistance utilization rate in the base year that is at least one standard deviation above the statewide mean utilization rate but is less than two and one-half standard deviations above the mean shall receive a factor of 0.2300; and

(6) a hospital that is a level one trauma center and that has a medical assistance utilization rate in the base year that is at least two and ~~one-half~~ one-quarter standard deviations above the statewide mean utilization rate shall receive a factor of 0.3711.

(e) For the purposes of determining eligibility for the disproportionate share hospital factors in paragraph (d), clauses (1) to (6), the medical assistance utilization rate and discharge thresholds shall be measured using only one year when a two-year base period is used.

(f) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

(g) An additional payment adjustment shall be established by the commissioner under this subdivision for a hospital that provides high levels of administering high-cost drugs to

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enrollees in fee-for-service medical assistance. The commissioner shall consider factors including fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, or if the hospital qualifies for the alternative payment rate described in subdivision 2e, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed ~~$1,500,000~~ $10,000,000. The department shall calculate the aggregate difference in payments for outpatient pharmacy claims for members enrolled with medical assistance prepaid health plans reimbursed at the 340B rate as compared to the non-340B rate, as defined in section 256B.0625. The department shall report the results to the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance hospital reimbursement no later than January 1 for the previous fiscal year.

EFFECTIVE DATE. This section is effective January 1, 2026, or the January 1 following certification of the modernized pharmacy claims processing system, whichever is later. The commissioner of human services shall notify the revisor of statutes when certification of the modernized pharmacy claims processing system occurs.

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enrollees in fee-for-service medical assistance. The commissioner shall consider factors including fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed $1,500,000.

Sec. 11. Minnesota Statutes 2022, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) Certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

(c) Upon federal approval of the related state plan amendment, paragraph (b) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology using 2012 as the base year. Annual payments made under this paragraph shall equal the total amount of payments made for 2012. A licensed children's hospital shall receive only a single DSH factor for children's hospitals. Other DSH factors may be combined to arrive at a single factor for each hospital that is eligible for DSH payments. The new methodology shall make payments only to hospitals located in Minnesota and include the following factors:

(1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000 fee-for-service discharges in the base year shall receive a factor of 0.7880;

(2) a hospital that has in effect for the initial rate year a contract with the commissioner to provide extended psychiatric inpatient services under section 256.9693 shall receive a factor of 0.0160;

(3) a hospital that has received medical assistance payment for at least 20 transplant services in the base year shall receive a factor of 0.0435;

(4) a hospital that has a medical assistance utilization rate in the base year between 20 percent up to one standard deviation above the statewide mean utilization rate shall receive a factor of 0.0468;

(5) a hospital that has a medical assistance utilization rate in the base year that is at least one standard deviation above the statewide mean utilization rate but is less than two and one-half standard deviations above the mean shall receive a factor of 0.2300; and

(6) a hospital that is a level one trauma center and that has a medical assistance utilization rate in the base year that is at least two and one-half standard deviations above the statewide mean utilization rate shall receive a factor of 0.3711.

(e) For the purposes of determining eligibility for the disproportionate share hospital factors in paragraph (d), clauses (1) to (6), the medical assistance utilization rate and discharge thresholds shall be measured using only one year when a two-year base period is used.

(f) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the number of fee-for-service discharges, to other DSH-eligible non-children's hospitals that have a medical assistance utilization rate that is at least one standard deviation above the mean.

(g) An additional payment adjustment shall be established by the commissioner under this subdivision for a hospital that provides high levels of administering high-cost drugs to

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enrollees in fee-for-service medical assistance. The commissioner shall consider factors including fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, or if the hospital qualifies for the alternative payment rate described in subdivision 2e, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed ~~$1,500,000~~ $10,000,000. The commissioner shall calculate the aggregate difference in payments for outpatient pharmacy claims for medical assistance enrollees receiving services from a managed care or county-based purchasing plan, when reimbursed at the 340B rate as compared to the non-340B rate, as specified in section 256B.0625, subdivision 13e. By February 1, 2026, the commissioner shall report the results of this calculation for the prior fiscal year to the chairs and ranking members of the legislative committees with jurisdiction over health care finance and policy.

EFFECTIVE DATE. This section is effective January 1, 2026, or the January 1 following certification of the modernized pharmacy claims processing system, whichever is later. The commissioner of human services shall notify the revisor of statutes when certification of the modernized pharmacy claims processing system occurs.

Sec. 6. Minnesota Statutes 2022, section 256.969, subdivision 25, is amended to read:

Subd. 25. **Long-term hospital rates.** (a) Long-term hospitals shall be paid on a per diem basis.

(b) For admissions occurring on or after April 1, 1995, a long-term hospital as designated by Medicare that does not have admissions in the base year shall have inpatient rates established at the average of other hospitals with the same designation. For subsequent rate-setting periods in which base years are updated, the hospital's base year shall be the first Medicare cost report filed with the long-term hospital designation and shall remain in effect until it falls within the same period as other hospitals.

(c) For admissions occurring on or after July 1, 2023, long-term hospitals must be paid the higher of a per diem amount computed using the methodology described in subdivision 2b, paragraph (i), or the per diem rate as of July 1, 2021.

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

Sec. 7. Minnesota Statutes 2022, section 256.969, subdivision 25, is amended to read:

Subd. 25. **Long-term hospital rates.** (a) Long-term hospitals shall be paid on a per diem basis.

(b) For admissions occurring on or after April 1, 1995, a long-term hospital as designated by Medicare that does not have admissions in the base year shall have inpatient rates established at the average of other hospitals with the same designation. For subsequent rate-setting periods in which base years are updated, the hospital's base year shall be the first Medicare cost report filed with the long-term hospital designation and shall remain in effect until it falls within the same period as other hospitals.

(c) For admissions occurring on or after July 1, 2023, long-term hospitals must be paid the higher of a per diem amount computed using the methodology described in subdivision 2b, paragraph (i), or the per diem rate as of July 1, 2021.

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

Sec. 8. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to read:

Subd. 31. **Long-acting reversible contraceptives.** (a) The commissioner must provide separate reimbursement to hospitals for long-acting reversible contraceptives provided immediately postpartum in the inpatient hospital setting. This payment must be in addition

Sec. 7. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to read:

Subd. 31. **Long-acting reversible contraceptives.** (a) The commissioner must provide separate reimbursement to hospitals for long-acting reversible contraceptives provided immediately postpartum in the inpatient hospital setting. This payment must be in addition

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to the diagnostic related group reimbursement for labor and delivery and shall be made consistent with section 256B.0625, subdivision 13e, paragraph (e).

(b) The commissioner must require managed care and county-based purchasing plans to comply with this subdivision when providing services to medical assistance enrollees.

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

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to the diagnostic-related group reimbursement for labor and delivery and shall be made consistent with section 256B.0625, subdivision 13e, paragraph (e).

(b) The commissioner must require managed care and county-based purchasing plans to comply with this subdivision when providing services to medical assistance enrollees.

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

Sec. 9. Minnesota Statutes 2022, section 256B.04, subdivision 14, is amended to read:

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

(1) eyeglasses;

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

(3) hearing aids and supplies;

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

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems; and

(ix) allergen-reducing products as described in section 256B.0625, subdivision 67, paragraph (c) or (d);

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; ~~and~~

(6) drugs.; and

(7) quitline services as described in section 256B.0625, subdivision 68, paragraph (c).

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Sec. 8. Minnesota Statutes 2022, section 256B.055, subdivision 17, is amended to read:

Subd. 17. **Adults who were in foster care at the age of 18.** (a) Medical assistance may be paid for a person under 26 years of age who was in foster care under the commissioner's responsibility on the date of attaining 18 years of age, and who was enrolled in medical assistance under the state plan or a waiver of the plan while in foster care, in accordance with section 2004 of the Affordable Care Act.

(b) Beginning July 1, 2023, medical assistance may be paid for a person under 26 years of age who was in foster care on the date of attaining 18 years of age and enrolled in another state's Medicaid program while in foster care in accordance with the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018. Public Law 115-271, section 1002.

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

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

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

~~(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:~~

~~(1) comprehensive exams, limited to once every five years;~~

~~(2) periodic exams, limited to one per year;~~

~~(3) limited exams;~~

~~(4) bitewing x-rays, limited to one per year;~~

~~(5) periapical x-rays;~~

~~(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once~~

(b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for special transportation services or incontinence products and related supplies.

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

Sec. 10. Minnesota Statutes 2022, section 256B.055, subdivision 17, is amended to read:

Subd. 17. **Adults who were in foster care at the age of 18.** (a) Medical assistance may be paid for a person under 26 years of age who was in foster care under the commissioner's responsibility on the date of attaining 18 years of age, and who was enrolled in medical assistance under the state plan or a waiver of the plan while in foster care, in accordance with section 2004 of the Affordable Care Act.

(b) Beginning July 1, 2023, medical assistance may be paid for a person under 26 years of age who was in foster care on the date of attaining 18 years of age and enrolled in another state's Medicaid program while in foster care in accordance with the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018. Public Law 115-271, section 1002.

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

Sec. 11. Minnesota Statutes 2022, section 256B.0625, subdivision 3a, is amended to read:

Subd. 3a. ~~**Sex reassignment surgery**~~ **Gender-affirming services**. ~~Sex reassignment surgery is not covered.~~ Medical assistance covers gender-affirming services.

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

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

~~(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:~~

~~(1) comprehensive exams, limited to once every five years;~~

~~(2) periodic exams, limited to one per year;~~

~~(3) limited exams;~~

~~(4) bitewing x-rays, limited to one per year;~~

~~(5) periapical x-rays;~~

~~(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once~~

~~every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;~~

~~(7) prophylaxis, limited to one per year;~~

~~(8) application of fluoride varnish, limited to one per year;~~

~~(9) posterior fillings, all at the amalgam rate;~~

~~(10) anterior fillings;~~

~~(11) endodontics, limited to root canals on the anterior and premolars only;~~

~~(12) removable prostheses, each dental arch limited to one every six years;~~

~~(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;~~

~~(14) palliative treatment and sedative fillings for relief of pain;~~

~~(15) full-mouth debridement, limited to one every five years; and~~

~~(16) nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures.~~

~~(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:~~

~~(1) periodontics, limited to periodontal scaling and root planing once every two years;~~

~~(2) general anesthesia; and~~

~~(3) full-mouth survey once every five years.~~

~~(d) Medical assistance covers medically necessary dental services for children and pregnant women.~~ (b) The following guidelines apply to dental services:

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

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

(3) application of fluoride varnish is covered once every six months~~; and~~.

~~(4) orthodontia is eligible for coverage for children only.~~

~~(c)~~ (c) In addition to the services specified in ~~paragraphs~~ paragraph (b) ~~and (c)~~, medical assistance covers the following services ~~for adults~~:

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

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

~~every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;~~

~~(7) prophylaxis, limited to one per year;~~

~~(8) application of fluoride varnish, limited to one per year;~~

~~(9) posterior fillings, all at the amalgam rate;~~

~~(10) anterior fillings;~~

~~(11) endodontics, limited to root canals on the anterior and premolars only;~~

~~(12) removable prostheses, each dental arch limited to one every six years;~~

~~(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;~~

~~(14) palliative treatment and sedative fillings for relief of pain;~~

~~(15) full-mouth debridement, limited to one every five years; and~~

~~(16) nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures.~~

~~(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:~~

~~(1) periodontics, limited to periodontal scaling and root planing once every two years;~~

~~(2) general anesthesia; and~~

~~(3) full-mouth survey once every five years.~~

~~(d) Medical assistance covers medically necessary dental services for children and pregnant women.~~ The following guidelines apply:

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

(2) application of sealants are covered once every five years per permanent molar ~~for children only~~;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

~~(c)~~ (b) In addition to the services specified in ~~paragraphs (b) and (c)~~ paragraph (a), medical assistance covers the following services ~~for adults~~:

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

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

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

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

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

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

Sec. 10. Minnesota Statutes 2022, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, a physician assistant, or an advanced practice registered nurse employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply~~;~~ unless authorized by the commissioner or as provided in paragraph (h) or the drug appears on the 90-day supply list published by the commissioner. The 90-day supply list shall be published by the commissioner on the department's website. The commissioner may add to, delete from, and otherwise modify the 90-day supply list after providing public notice and the opportunity for a 15-day public comment period. The 90-day supply list may include cost-effective generic drugs and shall not include controlled substances.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later.

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the Formulary Committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

(g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 16.

(h) Medical assistance coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive if a 12-month supply is prescribed by the prescribing health care provider. The prescribing health care provider must determine the appropriate duration for which to prescribe the prescription contraceptives, up to 12 months. For purposes of this paragraph, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent

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pregnancy. Prescription contraceptive does not include an emergency contraceptive drug approved to prevent pregnancy when administered after sexual contact. For purposes of this paragraph, "health plan" has the meaning provided in section 62Q.01, subdivision 3.

EFFECTIVE DATE. This section applies to medical assistance and MinnesotaCare coverage effective January 1, 2024.

Sec. 11. Minnesota Statutes 2022, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of ~~four~~ at least five licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom ~~must be actively engaged in the treatment of persons with mental illness~~ is an actively practicing psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one of whom specializes in pediatrics, and one of whom actively treats persons with disabilities; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota, one of whom practices outside the metropolitan counties listed in section 473.121, subdivision 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision 4, and one of whom is a practicing hospital pharmacist; ~~and one~~ at least four consumer ~~representative~~ representatives, all of whom must have a personal or professional connection to medical assistance; and one representative designated by the Minnesota Rare Disease Advisory Council established under section 256.4835; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed once by the commissioner. The committee members shall vote on a chair from among their membership. The chair shall preside over all committee meetings. The Formulary Committee shall meet at least ~~twice~~ four times per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. The Formulary Committee is subject to the Open Meeting Law under chapter 13D. The Formulary Committee expires June 30, ~~2023~~ 2027.

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

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Sec. 13. Minnesota Statutes 2022, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of ~~four~~ at least five licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom ~~must be actively engaged in the treatment of persons with mental illness~~ is an actively practicing psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one of whom specializes in pediatrics, and one of whom actively treats persons with disabilities; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota, one of whom practices outside the metropolitan counties listed in section 473.121, subdivision 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision 4, and one of whom is a practicing hospital pharmacist; ~~and one~~ at least four consumer ~~representative~~ representatives, all of whom must have a personal or professional connection to medical assistance; and one representative designated by the Minnesota Rare Disease Advisory Council established under section 256.4835; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least ~~twice~~ once per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. Notwithstanding section 15.059, subdivision 6, the Formulary Committee ~~expires June 30, 2023~~ does not expire.

Sec. 14. Minnesota Statutes 2022, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be $10.77 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be $10.77 per claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $10.77 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a

packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

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

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

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

(f) The commissioner may establish maximum allowable cost rates for specialty pharmacy products that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that

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Sec. 12. Minnesota Statutes 2022, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

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require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the maximum allowable cost to prevent access to care issues.

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

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

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

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

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

(d) Prior authorization shall not be required or utilized for:

(1) any liquid form of a medication for a patient who utilizes tube feedings of any kind, even if such patient has or had any paid claims for pills; and

(2) liquid methadone. If more than one version of liquid methadone is available, the commissioner shall select the version of liquid methadone that does not require prior authorization.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner.

(e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

~~(e)~~ (f) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

~~(f)~~ (g) Prior authorization under this subdivision shall comply with section 62Q.184.

~~(g)~~ (h) Any step therapy protocol requirements established by the commissioner must comply with section 62Q.1841.

Sec. 13. Minnesota Statutes 2022, section 256B.0625, subdivision 13g, is amended to read:

Subd. 13g. **Preferred drug list.** (a) The commissioner shall adopt and implement a preferred drug list by January 1, 2004. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred drug list and supplemental rebate program. The terms of the contract with the vendor must be publicly disclosed on the website of the Department of Human Services. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall publish the preferred drug list annually in the State Register and shall maintain an accurate and up-to-date list on the agency website. The commissioner shall implement and maintain an accurate archive of previous versions of the preferred drug list, and make this archive available to the public on the website of the Department of Human Services beginning January 1, 2024.

(b) The commissioner may add to, delete from, and otherwise modify the preferred drug list, after consulting with the Formulary Committee ~~and~~, appropriate medical specialists ~~and~~ , appropriate patient advocacy groups, and the Minnesota Rare Disease Advisory Council; providing public notice and the opportunity for public comment; and complying with the requirements of paragraph (f).

(c) The commissioner shall adopt and administer the preferred drug list as part of the administration of the supplemental drug rebate program. Reimbursement for prescription drugs not on the preferred drug list may be subject to prior authorization.

(d) For purposes of this subdivision, the following definitions apply:

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(1) "appropriate medical specialist" means a medical professional who prescribes the relevant class of drug as part of their subspecialty;

(2) "patient advocacy group" means a nonprofit organization as described in United States Code, title 26, section 501(c)(3), that is exempt from income tax under United States Code, title 26, section 501(a), or a public entity that supports persons with the disease state treated by the therapeutic class of the preferred drug list being updated; and

(3) "preferred drug list" means a list of prescription drugs within designated therapeutic classes selected by the commissioner, for which prior authorization based on the identity of the drug or class is not required.

(e) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision. The commissioner shall maintain a public list of applicable patient advocacy groups.

(f) ~~Notwithstanding paragraph (b),~~ Before the commissioner may delete a drug from the preferred drug list or modify the inclusion of a drug on the preferred drug list, the commissioner shall consider any implications that the deletion or modification may have on state public health policies or initiatives and any impact that the deletion or modification may have on increasing health disparities in the state. Prior to deleting a drug or modifying the inclusion of a drug, the commissioner shall also conduct a public hearing. The commissioner shall provide adequate notice to the public and the commissioner of health prior to the hearing that specifies the drug that the commissioner is proposing to delete or modify, and shall disclose any ~~public~~ medical or clinical analysis that the commissioner has relied on in proposing the deletion or modification, and evidence that the commissioner has evaluated the impact of the proposed deletion or modification on public health and health disparities. Notwithstanding section 331A.05, a public notice of a Formulary Committee meeting must be published at least 30 days in advance of the meeting. The list of drugs to be discussed at the meeting must be announced at least 30 days before the meeting and must include the name and class of drug, the proposed action, and the proposed prior authorization requirements, if applicable.

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Sec. 15. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13k. **Value-based purchasing arrangements.** (a) The commissioner may enter into a value-based purchasing arrangement under medical assistance or MinnesotaCare, by written arrangement with a drug manufacturer based on agreed-upon metrics. The commissioner may contract with a vendor to implement and administer the value-based purchasing arrangement. A value-based purchasing arrangement may include but is not limited to rebates, discounts, price reductions, risk sharing, reimbursements, guarantees, shared savings payments, withholds, or bonuses. A value-based purchasing arrangement

must provide at least the same value or discount in the aggregate as would claiming the mandatory federal drug rebate under the Federal Social Security Act, section 1927.

(b) Nothing in this section shall be interpreted as requiring a drug manufacturer or the commissioner to enter into an arrangement as described in paragraph (a).

(c) Nothing in this section shall be interpreted as altering or modifying medical assistance coverage requirements under the federal Social Security Act, section 1927.

(d) If the commissioner determines that a state plan amendment is necessary for implementation before implementing a value-based purchasing arrangement, the commissioner shall request the amendment and may delay implementing this provision until the amendment is approved.

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

Sec. 16. Minnesota Statutes 2022, section 256B.0625, subdivision 16, is amended to read:

Subd. 16. **Abortion services.** Medical assistance covers abortion services~~, but only if one of the following conditions is met:~~ determined to be medically necessary by the treating provider and delivered in accordance with all applicable Minnesota laws.

~~(a) The abortion is a medical necessity. "Medical necessity" means (1) the signed written statement of two physicians indicating the abortion is medically necessary to prevent the death of the mother, and (2) the patient has given her consent to the abortion in writing unless the patient is physically or legally incapable of providing informed consent to the procedure, in which case consent will be given as otherwise provided by law;~~

~~(b) The pregnancy is the result of criminal sexual conduct as defined in section 609.342, subdivision 1, clauses (a), (b), (c)(i) and (ii), and (e), and subdivision 1a, clauses (a), (b), (c)(i) and (ii), and (d), and the incident is reported within 48 hours after the incident occurs to a valid law enforcement agency for investigation, unless the victim is physically unable to report the criminal sexual conduct, in which case the report shall be made within 48 hours after the victim becomes physically able to report the criminal sexual conduct; or~~

~~(c) The pregnancy is the result of incest, but only if the incident and relative are reported to a valid law enforcement agency for investigation prior to the abortion.~~

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

Sec. 17. Minnesota Statutes 2022, section 256B.0625, subdivision 22, is amended to read:

Subd. 22. **Hospice care.** Medical assistance covers hospice care services under Public Law 99-272, section 9505, to the extent authorized by rule, except that a recipient age 21 or under who elects to receive hospice services does not waive coverage for services that are related to the treatment of the condition for which a diagnosis of terminal illness has

been made. Hospice respite and end-of-life care under subdivision 22a are not hospice care services under this subdivision.

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

Sec. 18. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

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

(b) The payment rates for coverage under this subdivision must be 100 percent of the Medicare rate for continuous home care hospice services as published in the Centers for Medicare and Medicaid Services annual final rule updating payments and policies for hospice care. The commissioner must seek to obtain federal financial participation for payment for hospice respite and end-of-life care under this subdivision. Payment must be made using state-only money, if federal financial participation is not obtained. Payment for hospice respite and end-of-life care must be paid to the residential hospice facility and are not included in any limit or cap amount applicable to hospice services payments to the elected hospice services provider.

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

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

Sec. 14. Minnesota Statutes 2022, section 256B.0625, subdivision 28b, is amended to read:

Subd. 28b. **Doula services.** Medical assistance covers doula services provided by a certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For purposes of this section, "doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum. The commissioner shall enroll doula agencies and individual treating doulas to provide direct reimbursement.

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

Sec. 19. Minnesota Statutes 2022, section 256B.0625, subdivision 28b, is amended to read:

Subd. 28b. **Doula services.** Medical assistance covers doula services provided by a certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For purposes of this section, "doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum. The commissioner shall enroll doula agencies and individual treating doulas to provide direct reimbursement.

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

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Sec. 15. Minnesota Statutes 2022, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. An FQHC that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not FQHCs or rural health clinics.

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

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

(f) Effective January 1, 2001, through December 31, 2020, each FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment

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Sec. 20. Minnesota Statutes 2022, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. An FQHC that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not FQHCs or rural health clinics.

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

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

(f) Effective January 1, 2001, through December 31, 2020, each FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment

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methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l), or, upon federal approval, for FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act, as provided under paragraph (k).

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

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

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

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

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

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

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

(i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner. the commissioner shall determine the most feasible method for paying claims from the following options:

(1) FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

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

(j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in

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methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l), or, upon federal approval, for FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act, as provided under paragraph (k).

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

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

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(1) FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

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

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accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

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

(k) The commissioner shall establish an encounter payment rate that is equivalent to the all inclusive rate (AIR) payment established by the Indian Health Service and published in the Federal Register. The encounter rate must be updated annually and must reflect the changes in the AIR established by the Indian Health Service each calendar year. FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act may elect to be paid: (1) at the encounter rate established under this paragraph; (2) under the alternative payment methodology described in paragraph (l); or (3) under the federally required prospective payment system described in paragraph (f). FQHCs that elect to be paid at the encounter rate established under this paragraph must continue to meet all state and federal requirements related to FQHCs and urban Indian organizations, and must maintain their statuses as FQHCs and urban Indian organizations.

(l) All claims for payment of clinic services provided by FQHCs and rural health clinics, that have elected to be paid under this paragraph, shall be paid by the commissioner according to the following requirements:

(1) the commissioner shall establish a single medical and single dental organization encounter rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization encounter rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social services and administrative costs;

(ii) retail pharmacy;

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accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

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(l) All claims for payment of clinic services provided by FQHCs and rural health clinics, that have elected to be paid under this paragraph, shall be paid by the commissioner according to the following requirements:

(1) the commissioner shall establish a single medical and single dental organization encounter rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization encounter rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social services and administrative costs;

(ii) retail pharmacy;

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(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fundraising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year. Years in which organizational cost or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency shall not be used as part of a base year when the base year includes more than one year. The commissioner may use the Medicare cost reports of a year unaffected by a

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(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fundraising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year. Years in which organizational cost or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency shall not be used as part of a base year when the base year includes more than one year. The commissioner may use the Medicare cost reports of a year unaffected by a

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pandemic, disease, or other public health emergency, or previous two consecutive years, inflated to the base year as established under item (iv);

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization encounter rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization encounter rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate currently received by the FQHC or rural health clinic;

(10) for FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

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pandemic, disease, or other public health emergency, or previous two consecutive years, inflated to the base year as established under item (iv);

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization encounter rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization encounter rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate currently received by the FQHC or rural health clinic;

(10) for FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

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(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rates;

(13) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

(14) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

(m) Effective July 1, 2023, an enrolled Indian health service facility or a Tribal health center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC. Requirements that otherwise apply to an FQHC covered in this subdivision do not apply to a Tribal FQHC enrolled under this paragraph, except that any requirements necessary to comply with federal regulations do apply to a Tribal FQHC. The commissioner shall establish an alternative payment method for a Tribal FQHC enrolled under this paragraph that uses the same method and rates applicable to a Tribal facility or health center that does not enroll as a Tribal FQHC.

EFFECTIVE DATE. This section 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. 16. Minnesota Statutes 2022, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions

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(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rates;

(13) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

(14) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

(m) Effective July 1, 2023, an enrolled Indian health service facility or a Tribal health center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC. Requirements that otherwise apply to an FQHC covered in this subdivision do not apply to a Tribal FQHC enrolled under this paragraph, except that any requirements necessary to comply with federal regulations do apply to a Tribal FQHC. The commissioner shall establish an alternative payment method for a Tribal FQHC enrolled under this paragraph that uses the same method and rates applicable to a Tribal facility or health center that does not enroll as a Tribal FQHC.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later, except that paragraph (m) is effective July 1, 2023. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2022, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions

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and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in Code of Federal Regulations, title 42, part 440.70.

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and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

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(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

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(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in Code of Federal Regulations, title 42, part 440.70.

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(h) Allergen-reducing products provided according to subdivision 67, paragraph (c) or (d), shall be considered durable medical equipment.

(i) Seizure detection devices are covered as durable medical equipment under this subdivision if:

(1) the seizure detection device is medically appropriate based on the recipient's medical condition or status; and

(2) the recipient's health care provider has identified that a seizure detection device would:

(i) likely assist in reducing bodily harm to or death of the recipient as a result of the recipient experiencing a seizure; or

(ii) provide data to the health care provider necessary to appropriately diagnose or treat a health condition of the recipient that causes the seizure activity.

(j) For purposes of paragraph (i), "seizure detection device" means a United States Food and Drug Administration-approved monitoring device and related service or subscription supporting the prescribed use of the device, including technology that provides ongoing patient monitoring and alert services that detect seizure activity and transmit notification of the seizure activity to a caregiver for appropriate medical response or collects data of the seizure activity of the recipient that can be used by a health care provider to diagnose or appropriately treat a health care condition that causes the seizure activity. The medical assistance reimbursement rate for a subscription supporting the prescribed use of a seizure detection device is 60 percent of the rate for monthly remote monitoring under the medical assistance telemonitoring benefit.

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

Sec. 17. Minnesota Statutes 2022, section 256B.0625, subdivision 34, is amended to read:

Subd. 34. **Indian health services facilities.** ~~(a)~~ Medical assistance payments and MinnesotaCare payments to facilities of the Indian health service and facilities operated by a Tribe or Tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, for enrollees who are eligible for federal financial participation, shall be at the option of the facility in accordance with the rate published by the United States Assistant Secretary for Health under the authority of United States Code, title 42, sections 248(a) and 249(b). MinnesotaCare payments for enrollees who are not eligible for federal financial participation at facilities of the Indian health service and facilities operated by a Tribe or Tribal organization for the provision of outpatient medical services must be in accordance with the medical assistance rates paid for the same services when provided

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(h) Allergen-reducing products provided according to subdivision 67, paragraph (c) or (d), shall be considered durable medical equipment.

(i) Seizure detection devices are covered as durable medical equipment under this subdivision if:

(1) the seizure detection device is medically appropriate based on the recipient's medical condition or status; and

(2) the recipient's health care provider has identified that a seizure detection device would:

(i) likely assist in reducing bodily harm to or death of the recipient as a result of the recipient experiencing a seizure; or

(ii) provide data to the health care provider necessary to appropriately diagnose or treat a health condition of the recipient that causes the seizure activity.

(j) For the purposes of paragraph (i), "seizure detection device" means a United States Food and Drug Administration-approved monitoring device and related service or subscription supporting the prescribed use of the device, including technology that provides ongoing patient monitoring and alert services that detect seizure activity and transmit notification of the seizure activity to a caregiver for appropriate medical response or collects data of the seizure activity of the recipient that can be used by a health care provider to diagnose or appropriately treat a health care condition that causes the seizure activity. The medical assistance reimbursement rate for a subscription supporting the prescribed use of a seizure detection device is 60 percent of the rate for monthly remote monitoring under the medical assistance telemonitoring benefit.

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

Sec. 22. Minnesota Statutes 2022, section 256B.0625, subdivision 34, is amended to read:

Subd. 34. **Indian health services facilities.** ~~(a)~~ Medical assistance payments and MinnesotaCare payments to facilities of the Indian health service and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, for enrollees who are eligible for federal financial participation, shall be at the option of the facility in accordance with the rate published by the United States Assistant Secretary for Health under the authority of United States Code, title 42, sections 248(a) and 249(b). MinnesotaCare payments for enrollees who are not eligible for federal financial participation at facilities of the Indian health service and facilities operated by a tribe or tribal organization for the provision of outpatient medical services must be in accordance with the medical assistance rates paid for the same services when provided in

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in a facility other than a facility of the Indian health service or a facility operated by a Tribe or Tribal organization.

~~(b) Effective upon federal approval, the medical assistance payments to a dually certified facility as defined in subdivision 30, paragraph (j), shall be the encounter rate described in paragraph (a) or a rate that is substantially equivalent for services provided to American Indians and Alaskan Native populations. The rate established under this paragraph for dually certified facilities shall not apply to MinnesotaCare payments.~~

EFFECTIVE DATE. This section 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. 18. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 68. **Biomarker testing.** Medical assistance covers biomarker testing to diagnose, treat, manage, and monitor illness or disease. Medical assistance coverage must meet the requirements that would otherwise apply to a health plan under section 62Q.473.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization.

~~(b) Effective upon federal approval, the medical assistance payments to a dually certified facility as defined in subdivision 30, paragraph (j), shall be the encounter rate described in paragraph (a) or a rate that is substantially equivalent for services provided to American Indians and Alaskan Native populations. The rate established under this paragraph for dually certified facilities shall not apply to MinnesotaCare payments.~~

EFFECTIVE DATE. This section 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. 23. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 68. **Tobacco and nicotine cessation.** (a) Medical assistance covers tobacco and nicotine cessation services, drugs to treat tobacco and nicotine addiction or dependence, and drugs to help individuals discontinue use of tobacco and nicotine products. Medical assistance must cover services and drugs as provided in this subdivision consistent with evidence-based or evidence-informed best practices.

(b) Medical assistance must cover in-person individual and group tobacco and nicotine cessation education and counseling services if provided by a health care practitioner whose scope of practice encompasses tobacco and nicotine cessation education and counseling. Service providers include but are not limited to the following:

(1) mental health practitioners under section 245.462, subdivision 17;

(2) mental health professionals under section 245.462, subdivision 18;

(3) mental health certified peer specialists under section 256B.0615;

(4) alcohol and drug counselors licensed under chapter 148F;

(5) recovery peers as defined in section 245F.02, subdivision 21;

(6) certified tobacco treatment specialists;

(7) community health workers;

(8) physicians;

(9) physician assistants;

(10) advanced practice registered nurses; or

(11) other licensed or nonlicensed professionals or paraprofessionals with training in providing tobacco and nicotine cessation education and counseling services.

(c) Medical assistance covers telephone cessation counseling services provided through a quitline. Notwithstanding section 256B.0625, subdivision 3b, quitline services may be provided through audio-only communications. The commissioner of human services may utilize volume purchasing for quitline services consistent with section 256B.04, subdivision 14.

(d) Medical assistance must cover all prescription and over-the-counter pharmacotherapy drugs approved by the United States Food and Drug Administration for cessation of tobacco and nicotine use or treatment of tobacco and nicotine dependence, and that are subject to a Medicaid drug rebate agreement.

(e) Services covered under this subdivision may be provided by telemedicine.

(f) The commissioner must not:

(1) restrict or limit the type, duration, or frequency of tobacco and nicotine cessation services;

(2) prohibit the simultaneous use of multiple cessation services, including but not limited to simultaneous use of counseling and drugs;

(3) require counseling before receiving drugs or as a condition of receiving drugs;

(4) limit pharmacotherapy drug dosage amounts for a dosing regimen for treatment of a medically accepted indication as defined in United States Code, title 14, section 1396r-8(K)(6); limit dosing frequency; or impose duration limits;

(5) prohibit simultaneous use of multiple drugs, including prescription and over-the-counter drugs;

(6) require or authorize step therapy; or

(7) require or utilize prior authorization for any tobacco and nicotine cessation services and drugs covered under this subdivision.

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Sec. 19. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 69. **Recuperative care services.** Medical assistance covers recuperative care services according to section 256B.0701.

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

UES2995-2, ARTICLE 1, SECTION 24, IS DUPLICATED TO APPEAR AS A MATCH TO BOTH S2995-3, ARTICLE 1, SECTIONS 19 AND 23

Sec. 24. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 69. **Recuperative care services.** (a) Medical assistance covers recuperative care services provided in a setting that meets the requirements in paragraph (b) for recipients who meet the eligibility requirements in paragraph (c). For purposes of this subdivision, "recuperative care" means a model of care that prevents hospitalization or that provides postacute medical care and support services for recipients experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living in a shelter or are otherwise unhoused but who are not sick enough to be hospitalized, or remain hospitalized, or to need other levels of care.

(b) Recuperative care may be provided in any setting, including but not limited to homeless shelters, congregate care settings, single-room occupancy settings, or supportive housing, so long as the provider of recuperative care or provider of housing is able to provide to the recipient within the designated setting, at a minimum:

(1) 24-hour access to a bed and bathroom;

(2) access to three meals a day;

(3) availability to environmental services;

(4) access to a telephone;

(5) a secure place to store belongings; and

(6) staff available within the setting to provide a wellness check as needed, but at a minimum at least once every 24 hours.

(c) To be eligible for this covered service, a recipient must:

(1) be 21 years of age or older;

(2) be experiencing homelessness;

(3) be in need of short-term acute medical care for a period of no more than 60 days;

(4) meet clinical criteria, as established by the commissioner, that indicates that the recipient is in need of recuperative care; and

(5) not have behavioral health needs that are greater than what can be managed by the provider within the setting.

(d) Payment for recuperative care shall consist of two components. The first component must be for the services provided to the member and is a bundled daily per diem payment

of at least $300 per day. The second component must be for the facility costs and must be paid using state funds equivalent to the amount paid as the medical assistance room and board rate and annual adjustments. The eligibility standards in chapter 256I shall not apply. The second component is only paid when the first component is paid to a provider. Providers may opt to only be reimbursed for the first component. A provider under this subdivision means a recuperative care provider and is defined by the standards established by the National Institute for Medical Respite Care. Services provided within the bundled payment may include but are not limited to:

(1) basic nursing care, including:

(i) monitoring a patient's physical health and pain level;

(ii) providing wound care;

(iii) medication support;

(iv) patient education;

(v) immunization review and update; and

(vi) establishing clinical goals for the recuperative care period and discharge plan;

(2) care coordination, including:

(i) initial assessment of medical, behavioral, and social needs;

(ii) development of a care plan;

(iii) support and referral assistance for legal services, housing, community social services, case management, health care benefits, health and other eligible benefits, and transportation needs and services; and

(iv) monitoring and follow-up to ensure that the care plan is effectively implemented to address the medical, behavioral, and social needs;

(3) basic behavioral needs, including counseling and peer support, that can be provided in this recuperative care setting; and

(4) services provided by a community health worker as defined under subdivision 49.

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

(f) If a recipient is temporarily absent due to an admission at a residential behavioral health facility, inpatient hospital, or nursing facility for a period of time exceeding the limits described in paragraph (d), the agency may request in a format prescribed by the

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

Sec. 20. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 70. **Coverage of services for the diagnosis, monitoring, and treatment of rare diseases.** (a) Medical assistance covers services related to the diagnosis, monitoring, and treatment of a rare disease or condition. Medical assistance coverage for these services must meet the requirements in section 62Q.451.

(b) Coverage for a service must not be denied solely on the basis that it was provided by, referred for, or ordered by an out-of-network provider.

(c) Any prior authorization requirements for a service that is provided by, referred for, or ordered by an out-of-network provider must be the same as any prior authorization requirements for a service that is provided by, referred for, or ordered by an in-network provider.

(d) Nothing in this subdivision requires a managed care or county-based purchasing plan to provide coverage for a service that is not covered under medical assistance.

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

Sec. 21. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 71. **Coverage and payment for pharmacy services.** (a) Medical assistance covers medical treatment or services provided by a licensed pharmacist, to the extent the medical treatment or services are within the pharmacist's scope of practice, if medical assistance

commissioner an absence day limit exception to continue payments until the recipient is discharged.

(g) The commissioner shall submit an initial report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy by February 1, 2025, and a final report by February 1, 2027, on coverage of recuperative care services. The reports must include but are not limited to:

(1) a list of the recuperative care services in Minnesota and the number of recipients;

(2) the estimated return on investment, including health care savings due to reduced hospitalizations;

(3) follow-up information, if available, on whether recipients' hospital visits decreased since recuperative care services were provided compared to before the services were provided; and

(4) any other information that can be used to determine the effectiveness of the program and its funding, including recommendations for improvements to the program.

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

covers the same medical treatment or services provided by a licensed physician. This requirement applies to services provided (1) under fee-for-service medical assistance, and (2) by a managed care plan under section 256B.69 or a county-based purchasing plan under section 256B.692.

(b) The commissioner, and managed care and county-based purchasing plans when providing services under sections 256B.69 and 256B.692, must reimburse a participating pharmacist or pharmacy for a service that is also within a physician's scope of practice at an amount no lower than the standard payment rate that would be applied when reimbursing a physician for the service.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2022, section 256B.0631, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services, including but not limited to the placement and removal of long-acting reversible contraceptives;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible;

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room;

(10) services, fee-for-service payments subject to volume purchase through competitive bidding;

(11) American Indians who meet the requirements in Code of Federal Regulations, title 42, sections 447.51 and 447.56;

(12) persons needing treatment for breast or cervical cancer as described under section 256B.057, subdivision 10; ~~and~~

(13) services that currently have a rating of A or B from the United States Preventive Services Task Force (USPSTF), immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130~~.~~; and

(14) additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

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

UES2995-2, ARTICLE 1, SECTION 24, IS DUPLICATED TO APPEAR AS A MATCH TO BOTH S2995-3, ARTICLE 1, SECTIONS 19 AND 23

Sec. 23. **[256B.0701] RECUPERATIVE CARE SERVICES.**

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

(b) "Provider" means a recuperative care provider as defined by the standards established by the National Institute for Medical Respite Care.

(c) "Recuperative care" means a model of care that prevents hospitalization or that provides postacute medical care and support services for recipients experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living in a shelter or are otherwise unhoused but who are not sick enough to be hospitalized or remain hospitalized, or to need other levels of care.

Subd. 2. **Recuperative care settings.** Recuperative care may be provided in any setting, including but not limited to homeless shelters, congregate care settings, single room occupancy settings, or supportive housing, so long as the provider of recuperative care or provider of housing is able to provide to the recipient within the designated setting, at a minimum:

(1) 24-hour access to a bed and bathroom;

(2) access to three meals a day;

(3) availability to environmental services;

(4) access to a telephone;

Sec. 24. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 69. **Recuperative care services.** (a) Medical assistance covers recuperative care services provided in a setting that meets the requirements in paragraph (b) for recipients who meet the eligibility requirements in paragraph (c). For purposes of this subdivision, "recuperative care" means a model of care that prevents hospitalization or that provides postacute medical care and support services for recipients experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living in a shelter or are otherwise unhoused but who are not sick enough to be hospitalized, or remain hospitalized, or to need other levels of care.

(b) Recuperative care may be provided in any setting, including but not limited to homeless shelters, congregate care settings, single-room occupancy settings, or supportive housing, so long as the provider of recuperative care or provider of housing is able to provide to the recipient within the designated setting, at a minimum:

(1) 24-hour access to a bed and bathroom;

(2) access to three meals a day;

(3) availability to environmental services;

(4) access to a telephone;

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(5) a secure place to store belongings; and

(6) staff available within the setting to provide a wellness check as needed, but at a minimum, at least once every 24 hours.

Subd. 3. **Eligibility.** To be eligible for recuperative care service, a recipient must:

(1) be 21 years of age or older;

(2) be experiencing homelessness;

(3) be in need of short-term acute medical care for a period of no more than 60 days;

(4) meet clinical criteria, as established by the commissioner, that indicates that the recipient needs recuperative care; and

(5) not have behavioral health needs that are greater than what can be managed by the provider within the setting.

Subd. 4. **Total payment rates.** Total payment rates for recuperative care consist of the recuperative care services rate and the recuperative care facility rate.

Subd. 5. **Recuperative care services rate.** The recuperative care services rate is for the services provided to the recipient and must be a bundled daily per diem payment of at least $300 per day. Services provided within the bundled payment may include but are not limited to:

(1) basic nursing care, including:

(i) monitoring a patient's physical health and pain level;

(ii) providing wound care;

(iii) medication support;

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(5) a secure place to store belongings; and

(6) staff available within the setting to provide a wellness check as needed, but at a minimum at least once every 24 hours.

(c) To be eligible for this covered service, a recipient must:

(1) be 21 years of age or older;

(2) be experiencing homelessness;

(3) be in need of short-term acute medical care for a period of no more than 60 days;

(4) meet clinical criteria, as established by the commissioner, that indicates that the recipient is in need of recuperative care; and

(5) not have behavioral health needs that are greater than what can be managed by the provider within the setting.

UES2995-2, ARTICLE 1, SECTION 24, PARAGRAPH (D), HAS BEEN DUPLICATED TO MATCH BOTH S2995-3, ARTICLE 1, SECTION 23, SUBDIVISIONS 5 AND 6. UES2995-2, ARTICLE 1, SECTION 24, PARAGRAPHS (E), (F), AND (G), HAVE BEEN MOVED TO MATCH S2995-3, ARTICLE 1, SECTION 23, SUBDIVISIONS 6, 7, AND 8.

(d) Payment for recuperative care shall consist of two components. The first component must be for the services provided to the member and is a bundled daily per diem payment of at least $300 per day. The second component must be for the facility costs and must be paid using state funds equivalent to the amount paid as the medical assistance room and board rate and annual adjustments. The eligibility standards in chapter 256I shall not apply. The second component is only paid when the first component is paid to a provider. Providers may opt to only be reimbursed for the first component. A provider under this subdivision means a recuperative care provider and is defined by the standards established by the National Institute for Medical Respite Care. Services provided within the bundled payment may include but are not limited to:

(1) basic nursing care, including:

(i) monitoring a patient's physical health and pain level;

(ii) providing wound care;

(iii) medication support;

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(iv) patient education;

(v) immunization review and update; and

(vi) establishing clinical goals for the recuperative care period and discharge plan;

(2) care coordination, including:

(i) initial assessment of medical, behavioral, and social needs;

(ii) development of a care plan;

(iii) support and referral assistance for legal services, housing, community social services, case management, health care benefits, health and other eligible benefits, and transportation needs and services; and

(iv) monitoring and follow-up to ensure that the care plan is effectively implemented to address the medical, behavioral, and social needs;

(3) basic behavioral needs, including counseling and peer support, that can be provided in this recuperative care setting; and

(4) services provided by a community health worker as defined under section 256B.0625, subdivision 49.

Subd. 6. **Recuperative care facility rate.** (a) The recuperative care facility rate is for facility costs and must be paid from state money in an amount equal to the medical assistance room and board rate at the time the recuperative care services were provided. The eligibility standards in chapter 256I do not apply to the recuperative care facility rate. The recuperative care facility rate is only paid when the recuperative care services rate is paid to a provider. Providers may opt to only receive the recuperative care services rate.

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

Subd. 7. **Extended stay.** If a recipient requires care exceeding the 60-day limit described in subdivision 3, the provider may request in a format prescribed by the commissioner an extension to continue payments until the recipient is discharged.

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(iv) patient education;

(v) immunization review and update; and

(vi) establishing clinical goals for the recuperative care period and discharge plan;

(2) care coordination, including:

(i) initial assessment of medical, behavioral, and social needs;

(ii) development of a care plan;

(iii) support and referral assistance for legal services, housing, community social services, case management, health care benefits, health and other eligible benefits, and transportation needs and services; and

(iv) monitoring and follow-up to ensure that the care plan is effectively implemented to address the medical, behavioral, and social needs;

(3) basic behavioral needs, including counseling and peer support, that can be provided in this recuperative care setting; and

(4) services provided by a community health worker as defined under subdivision 49.

UES2995-2, ARTICLE 1, SECTION 24, PARAGRAPH (D), HAS BEEN DUPLICATED TO MATCH BOTH S2995-3, ARTICLE 1, SECTION 23, SUBDIVISIONS 5 AND 6

(d) Payment for recuperative care shall consist of two components. The first component must be for the services provided to the member and is a bundled daily per diem payment of at least $300 per day. The second component must be for the facility costs and must be paid using state funds equivalent to the amount paid as the medical assistance room and board rate and annual adjustments. The eligibility standards in chapter 256I shall not apply. The second component is only paid when the first component is paid to a provider. Providers may opt to only be reimbursed for the first component. A provider under this subdivision means a recuperative care provider and is defined by the standards established by the National Institute for Medical Respite Care. Services provided within the bundled payment may include but are not limited to:

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

(f) If a recipient is temporarily absent due to an admission at a residential behavioral health facility, inpatient hospital, or nursing facility for a period of time exceeding the limits described in paragraph (d), the agency may request in a format prescribed by the

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Subd. 8. **Report.** (a) The commissioner must submit an initial report to the chairs and ranking minority members of the legislative committees having jurisdiction over health and human services by February 1, 2025, and a final report by February 1, 2027, on coverage of recuperative care services. The reports must include but are not limited to:

(1) a list of the recuperative care services in Minnesota and the number of recipients;

(2) the estimated return on investment, including health care savings due to reduced hospitalizations;

(3) follow-up information, if available, on whether recipients' hospital visits decreased since recuperative care services were provided compared to before the services were provided; and

(4) any other information that can be used to determine the effectiveness of the program and its funding, including recommendations for improvements to the program.

(b) This subdivision expires upon submission of the final report.

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

Sec. 24. Minnesota Statutes 2022, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

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commissioner an absence day limit exception to continue payments until the recipient is discharged.

(g) The commissioner shall submit an initial report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy by February 1, 2025, and a final report by February 1, 2027, on coverage of recuperative care services. The reports must include but are not limited to:

(1) a list of the recuperative care services in Minnesota and the number of recipients;

(2) the estimated return on investment, including health care savings due to reduced hospitalizations;

(3) follow-up information, if available, on whether recipients' hospital visits decreased since recuperative care services were provided compared to before the services were provided; and

(4) any other information that can be used to determine the effectiveness of the program and its funding, including recommendations for improvements to the program.

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

Sec. 25. Minnesota Statutes 2022, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

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(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed $6,000,000 per year. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to Regions Hospital by those plans. For the purposes of this paragraph, "the base amount" means the total annual value of increased medical assistance capitation payments, including the voluntary intergovernmental transfers, under this paragraph in calendar year 2017. For managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance capitation payments under this paragraph by an amount equal to ten percent of the base amount, and by an additional ten percent of the base amount for each subsequent contract year until December 31, 2025. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph. This paragraph expires January 1, 2026.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul, and ambulance services owned and operated by another governmental entity that chooses to participate by requesting the commissioner to

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(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed $6,000,000 per year. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to Regions Hospital by those plans. For the purposes of this paragraph, "the base amount" means the total annual value of increased medical assistance capitation payments, including the voluntary intergovernmental transfers, under this paragraph in calendar year 2017. For managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance capitation payments under this paragraph by an amount equal to ten percent of the base amount, and by an additional ten percent of the base amount for each subsequent contract year until December 31, 2025. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph. This paragraph expires January 1, 2026.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul, and ambulance services owned and operated by another governmental entity that chooses to participate by requesting the commissioner to

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determine an upper payment limit. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County, the city of St. Paul, and other participating governmental entities of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities. A Tribal government that owns and operates an ambulance service is not eligible to participate under this subdivision.

(e) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform the University of Minnesota Medical School and University of Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians equal to the difference between the established medical assistance payment for physician, dentist, and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians.

(f) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (e), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

(g) The payments in paragraphs (a) to (e) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

(h) All of the data and funding transactions related to the payments in paragraphs (a) to (e) shall be between the commissioner and the governmental entities. The commissioner shall not make payments to governmental entities eligible to receive payments described in paragraphs (a) to (e) that fail to submit the data needed to compute the payments within 24 months of the initial request from the commissioner.

(i) For purposes of this subdivision, billing professionals are limited to physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants,

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determine an upper payment limit. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County, the city of St. Paul, and other participating governmental entities of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities. A tribal government that owns and operates an ambulance service is not eligible to participate under this subdivision.

(e) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform the University of Minnesota Medical School and University of Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians equal to the difference between the established medical assistance payment for physician, dentist, and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians.

(f) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (e), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

(g) The payments in paragraphs (a) to (e) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

(h) All of the data and funding transactions related to the payments in paragraphs (a) to (e) shall be between the commissioner and the governmental entities. The commissioner shall not make payments to governmental entities eligible to receive payments described in paragraphs (a) to (e) that fail to submit the data needed to compute the payments within 24 months of the initial request from the commissioner.

(i) For purposes of this subdivision, billing professionals are limited to physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants,

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anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and dental therapists.

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

Sec. 25. Minnesota Statutes 2022, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **Limitation of choice; opportunity to opt out.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties, but shall provide all eligible individuals the opportunity to opt out of enrollment in managed care under this section. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

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anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and dental therapists.

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

THE FOLLOWING SECTION WAS MOVED IN FROM UES2995-2, ARTICLE 2, SECTION 15

Sec. 15. Minnesota Statutes 2022, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **Limitation of choice; opportunity to opt out.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties, but shall provide all eligible individuals the opportunity to opt out of enrollment in managed care under this section. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

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(8) persons eligible for medical assistance according to section 256B.057, subdivision 10;

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15; and

(10) persons who are absent from the state for more than 30 consecutive days but still deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision 1, paragraph (b).

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require, subject to the opt-out provision under paragraph (a), those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and given the opportunity to opt out of managed care enrollment. After notification, those individuals who choose not to opt out shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

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

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(8) persons eligible for medical assistance according to section 256B.057, subdivision 10;

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15; and

(10) persons who are absent from the state for more than 30 consecutive days but still deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision 1, paragraph (b).

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require, subject to the opt-out provision under paragraph (a), those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and given the opportunity to opt out of managed care enrollment. After notification, those individuals who choose not to opt out shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

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

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Sec. 26. Minnesota Statutes 2022, section 256B.69, subdivision 5a, is amended to read:

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

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

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

(d) The commissioner shall require that managed care plans:

(1) use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659 and community first services and supports under section 256B.85; and

(2) by January 30 of each year that follows a rate increase for any aspect of services under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over rates determined

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

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

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

(d) The commissioner shall require that managed care plans:

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(2) by January 30 of each year that follows a rate increase for any aspect of services under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over rates determined

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under section 256B.851 of the amount of the rate increase that is paid to each personal care assistance provider agency with which the plan has a contract.

~~(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2025.

Sec. 27. Minnesota Statutes 2022, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** (a) The commissioner ~~may~~ shall exclude or modify coverage for outpatient prescription drugs dispensed by a pharmacy to a medical assistance enrollee from the prepaid managed care contracts entered into under this section ~~in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates~~. The commissioner may include, exclude, or modify coverage for

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

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

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

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

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

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

THE FOLLOWING SECTION WAS MOVED IN FROM UES2995-2, ARTICLE 2, SECTION 16

Sec. 16. Minnesota Statutes 2022, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude or modify coverage for outpatient prescription drugs dispensed by a pharmacy to a medical assistance or MinnesotaCare enrollee from the prepaid managed care contracts entered into under this section ~~in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates~~ chapter and chapter 256L. The commissioner may

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outpatient prescription drugs dispensed by a pharmacy and administered to a MinnesotaCare enrollee from the prepaid managed care contracts entered into under this section.

(b) Managed care plans and county-based purchasing plans must reimburse pharmacies for outpatient drugs dispensed to enrollees as follows:

(1) for brand name drugs or multisource brand name drugs prescribed in accordance with Code of Federal Regulations, title 42, section 447.512(c), a dispensing fee equal to one-half of the fee-for-service dispensing fee in section 256B.0625, subdivision 13e, paragraph (a), plus the lesser of the National Average Drug Acquisition Cost for brand name drugs; the Wholesale Acquisition Cost minus two percent; the maximum allowable cost as defined in chapter 62W; or the submitted charges;

(2) for generic drugs or multisource brand name drugs, unless the multisource brand name drug is prescribed in accordance with Code of Federal Regulations, title 42, section 447.512(c), a dispensing fee equal to one-half of the fee-for-service dispensing fee in section 256B.0625, subdivision 13e, paragraph (a), plus the lesser of the National Average Drug Acquisition Cost for brand drugs; the National Average Drug Acquisition Cost for generic drugs; the Wholesale Acquisition Cost minus two percent; the maximum allowable cost; or the submitted charges;

(3) for drugs purchased through the 340B drug program, as allowed in section 62W.07, managed care plans and county-based purchasing plans may pay a rate less than the rate under clause (1) for brand name drugs or less than the rate under clause (2) for generic drugs, but are not required to apply the 340B drug ceiling price limit in section 256B.0625, subdivision 13e; and

(4) for charges submitted by a pharmacy that are less than the rate under clause (1) for brand name drugs or less than the rate under clause (2) for generic drugs, managed care plans and county-based purchasing plans may pay a lower rate equal to the submitted charges.

(c) Contracts between managed care plans and county-based purchasing plans and providers to whom paragraph (b) applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with paragraph (b). Payment recoveries must not exceed an amount equal to any increase in rates that results from paragraph (b). Paragraph (b) must not be implemented if federal approval is not received for paragraph (b), or if federal approval is withdrawn at any time.

EFFECTIVE DATE. The amendments to paragraph (a) are effective January 1, 2026, or the January 1 following certification of the modernized pharmacy claims processing system, whichever is later. Paragraphs (b) and (c) are effective January 1, 2024, or upon federal approval, whichever is later. The commissioner must inform the revisor of statutes

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include, exclude, or modify coverage for prescription drugs administered to a medical assistance or MinnesotaCare enrollee from the prepaid managed care contracts entered into under this chapter and chapter 256L.

EFFECTIVE DATE. This section is effective January 1, 2026, or the January 1 following certification of the modernized pharmacy claims processing system, whichever is later. The commissioner of human services shall notify the revisor of statutes when certification of the modernized pharmacy claims processing system occurs.

when federal approval is obtained and when certification of the modernized pharmacy claims processing system occurs.

Sec. 28. Minnesota Statutes 2022, section 256B.69, is amended by adding a subdivision to read:

Subd. 19a. **Limitation on reimbursement; rare disease services provided in Minnesota by out-of-network providers.** (a) If a managed care or county-based purchasing plan has an established contractual payment under medical assistance with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition, the provider must accept the established contractual payment for that service as payment in full.

(b) If a plan does not have an established contractual payment under medical assistance with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition, the provider must accept the provider's established rate for uninsured patients for that service as payment in full. If the provider does not have an established rate for uninsured patients for that service, the provider must accept the fee-for-service rate.

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

Sec. 29. Minnesota Statutes 2022, section 256B.69, is amended by adding a subdivision to read:

Subd. 19b. **Limitation on reimbursement; rare disease services provided outside of Minnesota by an out-of-network provider.** (a) If a managed care or county-based purchasing plan has an established contractual payment under medical assistance with an out-of-network provider for a service provided in another state related to diagnosis, monitoring, and treatment of a rare disease or condition, the plan must pay the established contractual payment for that service.

(b) If a plan does not have an established contractual payment under medical assistance with an out-of-network provider for a service provided in another state related to diagnosis, monitoring, and treatment of a rare disease or condition, the plan must pay the provider's established rate for uninsured patients for that service. If the provider does not have an established rate for uninsured patients for that service, the plan must pay the provider the fee-for-service rate in that state.

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

THE FOLLOWING SECTION WAS MOVED IN FROM UES2995-2, ARTICLE 2, SECTION 17

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Sec. 30. Minnesota Statutes 2022, section 256B.69, subdivision 28, is amended to read:

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with demonstration providers and current or former sponsors of qualified Medicare-approved special needs plans, to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/DD services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

(b) The commissioner may contract with demonstration providers and current and former sponsors of qualified Medicare special needs plans, to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) ~~Notwithstanding subdivision 4, beginning January 1, 2012,~~ The commissioner shall enroll persons with disabilities in managed care under this section, unless the individual chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out procedures consistent with applicable enrollment procedures under this section.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

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Sec. 17. Minnesota Statutes 2022, section 256B.69, subdivision 28, is amended to read:

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with demonstration providers and current or former sponsors of qualified Medicare-approved special needs plans, to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/DD services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

(b) The commissioner may contract with demonstration providers and current and former sponsors of qualified Medicare special needs plans, to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) ~~Notwithstanding subdivision 4, beginning January 1, 2012,~~ The commissioner shall enroll persons with disabilities in managed care under this section, unless the individual chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out procedures consistent with applicable enrollment procedures under this section.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

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(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner shall mail no more than two sets of marketing materials per contract year to potential enrollees on behalf of health plans, at the health plan's request. The marketing materials shall be mailed by the commissioner within 30 days of receipt of these materials from the health plan. The health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

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

Sec. 31. Minnesota Statutes 2022, section 256B.69, subdivision 36, is amended to read:

Subd. 36. **Enrollee support system.** (a) The commissioner shall establish an enrollee support system that provides support to an enrollee before and during enrollment in a managed care plan.

(b) The enrollee support system must:

(1) provide access to counseling for each potential enrollee on choosing a managed care plan or opting out of managed care;

(2) assist an enrollee in understanding enrollment in a managed care plan;

(3) provide an access point for complaints regarding enrollment, covered services, and other related matters;

(4) provide information on an enrollee's grievance and appeal rights within the managed care organization and the state's fair hearing process, including an enrollee's rights and responsibilities; and

(5) provide assistance to an enrollee, upon request, in navigating the grievance and appeals process within the managed care organization and in appealing adverse benefit determinations made by the managed care organization to the state's fair hearing process after the managed care organization's internal appeals process has been exhausted. Assistance does not include providing representation to an enrollee at the state's fair hearing, but may include a referral to appropriate legal representation sources.

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(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner shall mail no more than two sets of marketing materials per contract year to potential enrollees on behalf of health plans, at the health plan's request. The marketing materials shall be mailed by the commissioner within 30 days of receipt of these materials from the health plan. The health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

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

THE FOLLOWING SECTION WAS MOVED IN FROM UES2995-2, ARTICLE 2, SECTION 18

Sec. 18. Minnesota Statutes 2022, section 256B.69, subdivision 36, is amended to read:

Subd. 36. **Enrollee support system.** (a) The commissioner shall establish an enrollee support system that provides support to an enrollee before and during enrollment in a managed care plan.

(b) The enrollee support system must:

(1) provide access to counseling for each potential enrollee on choosing a managed care plan or opting out of managed care;

(2) assist an enrollee in understanding enrollment in a managed care plan;

(3) provide an access point for complaints regarding enrollment, covered services, and other related matters;

(4) provide information on an enrollee's grievance and appeal rights within the managed care organization and the state's fair hearing process, including an enrollee's rights and responsibilities; and

(5) provide assistance to an enrollee, upon request, in navigating the grievance and appeals process within the managed care organization and in appealing adverse benefit determinations made by the managed care organization to the state's fair hearing process after the managed care organization's internal appeals process has been exhausted. Assistance does not include providing representation to an enrollee at the state's fair hearing, but may include a referral to appropriate legal representation sources.

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(c) Outreach to enrollees through the support system must be accessible to an enrollee through multiple formats, including telephone, Internet, in-person, and, if requested, through auxiliary aids and services.

(d) The commissioner may designate enrollment brokers to assist enrollees on selecting a managed care organization and providing necessary enrollment information. For purposes of this subdivision, "enrollment broker" means an individual or entity that performs choice counseling or enrollment activities in accordance with Code of Federal Regulations, part 42, section 438.810, or both.

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

Sec. 32. Minnesota Statutes 2022, section 256B.692, subdivision 1, is amended to read:

Subdivision 1. **In general.** County boards or groups of county boards may elect to purchase or provide health care services on behalf of persons eligible for medical assistance who would otherwise be required to or may elect to participate in the prepaid medical assistance program according to section 256B.69, subject to the opt-out provision of section 256B.69, subdivision 4, paragraph (a). Counties that elect to purchase or provide health care under this section must provide all services included in prepaid managed care programs according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this section is governed by section 256B.69, unless otherwise provided for under this section.

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

Sec. 33. Minnesota Statutes 2022, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner

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(c) Outreach to enrollees through the support system must be accessible to an enrollee through multiple formats, including telephone, Internet, in-person, and, if requested, through auxiliary aids and services.

(d) The commissioner may designate enrollment brokers to assist enrollees on selecting a managed care organization and providing necessary enrollment information. For purposes of this subdivision, "enrollment broker" means an individual or entity that performs choice counseling or enrollment activities in accordance with Code of Federal Regulations, part 42, section 438.810, or both.

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

THE FOLLOWING SECTION WAS MOVED IN FROM UES2995-2, ARTICLE 2, SECTION 19

Sec. 19. Minnesota Statutes 2022, section 256B.692, subdivision 1, is amended to read:

Subdivision 1. **In general.** County boards or groups of county boards may elect to purchase or provide health care services on behalf of persons eligible for medical assistance who would otherwise be required to or may elect to participate in the prepaid medical assistance program according to section 256B.69, subject to the opt-out provision of section 256B.69, subdivision 4, paragraph (a). Counties that elect to purchase or provide health care under this section must provide all services included in prepaid managed care programs according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this section is governed by section 256B.69, unless otherwise provided for under this section.

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

THE FOLLOWING SECTION WAS MOVED IN FROM UES2995-2, ARTICLE 2, SECTION 20

Sec. 20. Minnesota Statutes 2022, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner

may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics.

(c) The rate described in paragraph (b) must be increased for hospitals providing high levels of 340B drugs. The rate adjustment must be based on four percent of each hospital's share of the total reimbursement for 340B drugs to all critical access hospitals, but must not exceed $3,000,000.

~~(c)~~ (d) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision. When implementing prospective payment methodologies, the commissioner shall use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified in this chapter.

~~(d)~~ (e) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

~~(e)~~ (f) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b)(1) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics.

(2) The rate described in clause (1) must be increased for hospitals providing high levels of 340B drugs. The rate adjustment must be based on four percent of each hospital's share of the total reimbursement for 340B drugs to all critical access hospitals, but must not exceed $3,000,000.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision. When implementing prospective payment methodologies, the commissioner shall use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified in this chapter.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

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~~(f)~~ (g) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

EFFECTIVE DATE. This section is effective January 1, 2026, or the January 1 following certification of the modernized pharmacy claims processing system, whichever is later. The commissioner of human services shall notify the revisor of statutes when certification of the modernized pharmacy claims processing system occurs.

Sec. 34. Minnesota Statutes 2022, section 256B.758, is amended to read:

256B.758 REIMBURSEMENT FOR DOULA SERVICES.

(a) Effective for services provided on or after July 1, 2019, through December 31, 2023, payments for doula services provided by a certified doula shall be $47 per prenatal or postpartum visit and $488 for attending and providing doula services at a birth.

(b) Effective for services provided on or after January 1, 2024, payments for doula services provided by a certified doula are $100 per prenatal or postpartum visit and $1,400 for attending and providing doula services at birth.

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

Sec. 35. Minnesota Statutes 2022, section 256B.76, as amended by Laws 2023, chapter 25, section 145, is amended to read:

256B.76 PHYSICIAN, PROFESSIONAL SERVICES, AND DENTAL REIMBURSEMENT.

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

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(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

EFFECTIVE DATE. This section is effective January 1, 2026, or the January 1 following certification of the modernized pharmacy claims processing system, whichever is later. The commissioner of human services shall notify the revisor of statutes when certification of the modernized pharmacy claims processing system occurs.

Sec. 27. Minnesota Statutes 2022, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician 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

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(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,

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(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 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 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,

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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) 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) 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) 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.

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered ~~on or after~~ from October 1, 1992, to December 31, 2023, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental 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.

(b) ~~Beginning~~ From October 1, 1999, to December 31, 2023, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered ~~on or after~~ from January 1, 2000, to December 31, 2023, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided ~~on or after~~ from January 1, 2002, to December 31, 2023, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

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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) 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) 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) The commissioner may reimburse the cost incurred to pay the Department of Health for metabolic disorder testing of newborns who are medical assistance recipients when the sample is collected outside of an inpatient hospital setting or freestanding birth center setting because the newborn was born outside of a hospital setting or freestanding birth center setting or because it is not medically appropriate to collect the sample during the inpatient stay for the birth.

Sec. 28. Minnesota Statutes 2022, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered ~~on or after~~ from October 1, 1992, to December 31, 2023, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental 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.

(b) ~~Beginning~~ From October 1, 1999, to December 31, 2023, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered ~~on or after~~ from January 1, 2000, to December 31, 2023, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided ~~on or after~~ from January 1, 2002, to December 31, 2023, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

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(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

~~(h) Effective for services rendered on or after January 1, 2014, through December 31, 2021, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.~~

~~(i) Effective for services provided on or after January 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.~~

~~(j) Effective for services provided on or after July 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 23.8 percent for dental services provided to enrollees under the age of 21. This rate increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers. This rate increase does not apply to managed care plans and county-based purchasing plans.~~

~~(k)~~ (h) Effective for services provided on or after January 1, 2022, the commissioner shall exclude from medical assistance and MinnesotaCare payments for dental services to public health and community health clinics the 20 percent increase authorized under Laws 1989, chapter 327, section 5, subdivision 2, paragraph (b).

~~(l)~~ (i) Effective for services provided ~~on or after~~ from January 1, 2022, to December 31, 2023, the commissioner shall increase payment rates by 98 percent for all dental services. This rate increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, or Indian health services.

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(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

~~(h) Effective for services rendered on or after January 1, 2014, through December 31, 2021, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.~~

~~(i) Effective for services provided on or after January 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.~~

~~(j) Effective for services provided on or after July 1, 2017, through December 31, 2021, the commissioner shall increase payment rates by 23.8 percent for dental services provided to enrollees under the age of 21. This rate increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers. This rate increase does not apply to managed care plans and county-based purchasing plans.~~

~~(k)~~ (h) Effective for services provided on or after January 1, 2022, the commissioner shall exclude from medical assistance and MinnesotaCare payments for dental services to public health and community health clinics the 20 percent increase authorized under Laws 1989, chapter 327, section 5, subdivision 2, paragraph (b).

~~(l)~~ (i) Effective for services provided ~~on or after~~ from January 1, 2022, to December 31, 2023, the commissioner shall increase payment rates by 98 percent for all dental services. This rate increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, or Indian health services.

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~~(m)~~ (j) Managed care plans and county-based purchasing plans shall reimburse providers at a level that is at least equal to the rate paid under fee-for-service for dental services. If, for any coverage 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 an amount equal to any increase in rates that results from this provision. If, for any coverage year, federal approval is not received for this paragraph, the commissioner shall not implement this paragraph for subsequent coverage years.

(k) Effective for services provided on or after January 1, 2024, payment for dental services must be the lower of submitted charges or the percentile of 2018-submitted charges from claims paid by the commissioner so that the total aggregate expenditures does not exceed the total spend as outlined in the applicable paragraphs (a) to (k). This paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

(l) Beginning January 1, 2027, and every three years thereafter, the commissioner shall rebase payment rates for dental services to a percentile of submitted charges for the applicable base year using charge data from claims paid by the commissioner so that the total aggregate expenditures does not exceed the total spend as outlined in paragraph (k) plus the change in the Medicare Economic Index (MEI). In 2027, the change in the MEI must be measured from midyear of 2024 and 2026. For each subsequent rebasing, the change in the MEI must be measured between the years that are one year after the rebasing years. The base year used for each rebasing must be the calendar year that is two years prior to the effective date of the rebasing. This paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

Subd. 3. **Dental services grants.** (a) The commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region. In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

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~~(m)~~ (j) Managed care plans and county-based purchasing plans shall reimburse providers at a level that is at least equal to the rate paid under fee-for-service for dental services. If, for any coverage 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 an amount equal to any increase in rates that results from this provision. If, for any coverage year, federal approval is not received for this paragraph, the commissioner shall not implement this paragraph for subsequent coverage years.

(k) Effective for services provided on or after January 1, 2024, payment for dental services must be the lower of submitted charges or the percentile of 2018-submitted charges from claims paid by the commissioner so that the total aggregate expenditures does not exceed the total spend as outlined in the applicable paragraphs (a) to (k). This paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

(l) Beginning January 1, 2028, and every three years thereafter, the commissioner shall rebase payment rates for dental services to a percentile of submitted charges for the applicable base year using charge data from claims paid by the commissioner so that the total aggregate expenditures does not exceed the total spend as outlined in paragraph (k) plus the change in the Medicare Economic Index (MEI). In 2028, the change in the MEI must be measured from midyear of 2025 and 2027. For each subsequent rebasing, the change in the MEI must be measured between the years that are one year after the rebasing years. The base year used for each rebasing must be the calendar year that is two years prior to the effective date of the rebasing. This paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

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(1) potential to successfully increase access to an underserved population;

(2) the ability to raise matching funds;

(3) the long-term viability of the project to improve access beyond the period of initial funding;

(4) the efficiency in the use of the funding; and

(5) the experience of the proposers in providing services to the target population.

(b) The commissioner shall monitor the grants and may terminate a grant if the grantee does not increase dental access for public program recipients. The commissioner shall consider grants for the following:

(1) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(2) a pilot program for utilizing hygienists outside of a traditional dental office to provide dental hygiene services; and

(3) a program that organizes a network of volunteer dentists, establishes a system to refer eligible individuals to volunteer dentists, and through that network provides donated dental care services to public program recipients or uninsured individuals.

Subd. 4. **Critical access dental providers.** ~~(a) The commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2016, through December 31, 2021, the commissioner shall increase reimbursement by 37.5 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.~~

~~(b) For dental services rendered on or after July 1, 2016, through December 31, 2021, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (f), clause (4), and is owned and operated by a health maintenance organization licensed under chapter 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.~~

~~(c)~~ (a) The commissioner shall increase reimbursement to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services provided on or after January 1, 2022, by a dental provider deemed to be a critical access dental provider under paragraph ~~(f)~~ (d), the commissioner shall increase reimbursement by 20 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. This paragraph does not apply to federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers.

~~(d)~~ (b) Managed care plans and county-based purchasing plans shall increase reimbursement to critical access dental providers by at least the amount specified in paragraph ~~(c)~~ (c). If, for any coverage 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 an amount equal to any increase in rates that results from this provision. If, for any coverage year, federal approval is not received for this paragraph, the commissioner shall not implement this paragraph for subsequent coverage years.

~~(e)~~ (c) Critical access dental payments made under this subdivision for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

~~(f)~~ (d) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) hospital-based dental clinics owned and operated by a city, county, or former state hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

(i) the dentist's office is located within the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; or

(ii) the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

Subd. 5. **Outpatient rehabilitation facility.** An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, and for whom at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under subdivision 1, paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

Subd. 6. **Medicare relative value units.** 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 (RVU's). This change shall be budget neutral and the cost of implementing RVU's will be incorporated in the established conversion factor.

Subd. 7. **Payment for certain primary care services and immunization administration.** Payment for certain primary care services and immunization administration services rendered on or after January 1, 2013, through December 31, 2014, shall be made in accordance with section 1902(a)(13) of the Social Security Act.

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

Sec. 36. Minnesota Statutes 2022, 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 256E.12. 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, must be increased by eight 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, must be annually adjusted according to the Consumer Price Index for medical care services. 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

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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.

Sec. 37. Minnesota Statutes 2022, section 256B.764, is amended to read:

256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.

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

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

(c) Effective for services provided on or after January 1, 2024, payment rates for family planning and abortion services must be increased by ten percent. This increase does not apply to federally qualified health centers, rural health centers, or Indian health services.

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Sec. 29. Minnesota Statutes 2022, section 256B.764, is amended to read:

256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.

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

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

(c) Effective for services provided on or after January 1, 2024, payment rates for family planning and abortion services shall be increased by 20 percent. This increase does not apply to federally qualified health centers, rural health centers, or Indian health services.

Sec. 30. Minnesota Statutes 2022, section 256L.03, subdivision 1, is amended to read:

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

~~(b) No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment~~

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~~of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.~~

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

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

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

S2995-3, ARTICLE 1, SECTION 38, MATCHES THE NEXT THREE SUBSEQUENT SECTIONS.

Sec. 38. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

Sec. 31. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 ~~and~~, to American Indians as defined in Code of Federal Regulations, title 42, section 600.5; or to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(b) The commissioner ~~shall~~ must adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

(d) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

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

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

UES2995-2, ARTICLE 13, SECTIONS 15 AND 16 HAVE BEEN MOVED IN TO MATCH S2995-3, ARTICLE 1, SECTION 38.

Sec. 15. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

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(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Cost-sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

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

Sec. 16. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

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

Sec. 39. Laws 2021, First Special Session chapter 7, article 6, section 26, is amended to read:

Sec. 26. **COMMISSIONER OF HUMAN SERVICES; EXTENSION OF COVID-19 HUMAN SERVICES PROGRAM MODIFICATIONS.**

Notwithstanding Laws 2020, First Special Session chapter 7, section 1, subdivision 2, as amended by Laws 2020, Third Special Session chapter 1, section 3, when the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, the following modifications issued by the commissioner of human services pursuant to Executive Orders 20-11 and 20-12, and

Sec. 32. Laws 2021, First Special Session chapter 7, article 6, section 26, is amended to read:

Sec. 26. **COMMISSIONER OF HUMAN SERVICES; EXTENSION OF COVID-19 HUMAN SERVICES PROGRAM MODIFICATIONS.**

Notwithstanding Laws 2020, First Special Session chapter 7, section 1, subdivision 2, as amended by Laws 2020, Third Special Session chapter 1, section 3, when the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, the following modifications issued by the commissioner of human services pursuant to Executive Orders 20-11 and 20-12, and

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including any amendments to the modification issued before the peacetime emergency expires, shall remain in effect until July 1, ~~2023~~ 2025:

(1) CV16: expanding access to telemedicine services for Children's Health Insurance Program, Medical Assistance, and MinnesotaCare enrollees; and

(2) CV21: allowing telemedicine alternative for school-linked mental health services and intermediate school district mental health services.

Sec. 40. **REPORT; MODIFY WITHHOLD PROVISIONS.**

By January 1, 2024, the commissioner of human services must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy evaluating the utility of the performance targets described in Minnesota Statutes 2022, section 256B.69, subdivision 5a, paragraphs (e) to (g). The report must include the applicable performance rates of managed care organizations and county-based purchasing plans in the past three years, projected impacts on performance rates for the next three years resulting from a repeal of Minnesota Statutes 2022, section 256B.69, subdivision 5a, paragraphs (e) to (g), measures that the commissioner anticipates taking to continue monitoring and improving the applicable performance rates of managed care organizations and county-based purchasing plans upon a repeal of Minnesota Statutes 2022, section 256B.69, subdivision 5a, paragraphs (e) to (g), proposals for additional performance targets that may improve quality of care for enrollees, and any additional legislative actions that may be required as the result of a repeal of Minnesota Statutes 2022, section 256B.69, subdivision 5a, paragraphs (e) to (g).

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including any amendments to the modification issued before the peacetime emergency expires, shall remain in effect until July 1, ~~2023~~ 2025:

(1) CV16: expanding access to telemedicine services for Children's Health Insurance Program, Medical Assistance, and MinnesotaCare enrollees; and

(2) CV21: allowing telemedicine alternative for school-linked mental health services and intermediate school district mental health services.

Sec. 33. **REPEALER.**

Minnesota Rules, part 9505.0235, is repealed the day following final enactment.