

3.39

ARTICLE 1

3.40

HEALTH CARE

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

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

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

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

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

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

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

3.13

ARTICLE 1

3.14

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.

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

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

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

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

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

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

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

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

5.1 Sec. 4. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

5.2 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November  
5.3 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according  
5.4 to the following:

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

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

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

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

5.13 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not  
5.14 be rebased, except that a Minnesota long-term hospital shall be rebased effective January  
5.15 1, 2011, based on its most recent Medicare cost report ending on or before September 1,  
5.16 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on  
5.17 December 31, 2010. For rate setting periods after November 1, 2014, in which the base  
5.18 years are updated, a Minnesota long-term hospital's base year shall remain within the same  
5.19 period as other hospitals.

5.20 (c) Effective for discharges occurring on and after November 1, 2014, payment rates  
5.21 for hospital inpatient services provided by hospitals located in Minnesota or the local trade  
5.22 area, except for the hospitals paid under the methodologies described in paragraph (a),  
5.23 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a  
5.24 manner similar to Medicare. The base year or years for the rates effective November 1,  
5.25 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,  
5.26 ensuring that the total aggregate payments under the rebased system are equal to the total  
5.27 aggregate payments that were made for the same number and types of services in the base  
5.28 year. Separate budget neutrality calculations shall be determined for payments made to  
5.29 critical access hospitals and payments made to hospitals paid under the DRG system. Only  
5.30 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being

7.10 Sec. 5. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

7.11 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November  
7.12 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according  
7.13 to the following:

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

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

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

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

7.22 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not  
7.23 be rebased, except that a Minnesota long-term hospital shall be rebased effective January  
7.24 1, 2011, based on its most recent Medicare cost report ending on or before September 1,  
7.25 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on  
7.26 December 31, 2010. For rate setting periods after November 1, 2014, in which the base  
7.27 years are updated, a Minnesota long-term hospital's base year shall remain within the same  
7.28 period as other hospitals.

7.29 (c) Effective for discharges occurring on and after November 1, 2014, payment rates  
7.30 for hospital inpatient services provided by hospitals located in Minnesota or the local trade  
7.31 area, except for the hospitals paid under the methodologies described in paragraph (a),  
7.32 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a  
7.33 manner similar to Medicare. The base year or years for the rates effective November 1,  
8.1 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,  
8.2 ensuring that the total aggregate payments under the rebased system are equal to the total  
8.3 aggregate payments that were made for the same number and types of services in the base  
8.4 year. Separate budget neutrality calculations shall be determined for payments made to  
8.5 critical access hospitals and payments made to hospitals paid under the DRG system. Only  
8.6 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being

5.31 rebased during the entire base period shall be incorporated into the budget neutrality  
5.32 calculation.

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

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

6.11 (1) pediatric services;

6.12 (2) behavioral health services;

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

6.14 (4) transplant services;

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

6.17 (6) outlier admissions;

6.18 (7) low-volume providers; and

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

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

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

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

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

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

8.7 rebased during the entire base period shall be incorporated into the budget neutrality  
8.8 calculation.

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

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

8.19 (1) pediatric services;

8.20 (2) behavioral health services;

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

8.22 (4) transplant services;

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

8.25 (6) outlier admissions;

8.26 (7) low-volume providers; and

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

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

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

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

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

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

7.3 methods and allowable costs of the Medicare program in effect during the base year or  
7.4 years.

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

7.10 (h) Effective for discharges occurring on or after July 1, 2017, and every two years  
7.11 thereafter, payment rates under this section shall be rebased to reflect only those changes  
7.12 in hospital costs between the existing base year or years and the next base year or years. In  
7.13 any year that inpatient claims volume falls below the threshold required to ensure a  
7.14 statistically valid sample of claims, the commissioner may combine claims data from two  
7.15 consecutive years to serve as the base year. Years in which inpatient claims volume is  
7.16 reduced or altered due to a pandemic or other public health emergency shall not be used as  
7.17 a base year or part of a base year if the base year includes more than one year. Changes in  
7.18 costs between base years shall be measured using the lower of the hospital cost index defined  
7.19 in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per  
7.20 claim. The commissioner shall establish the base year for each rebasing period considering  
7.21 the most recent year or years for which filed Medicare cost reports are available. The  
7.22 estimated change in the average payment per hospital discharge resulting from a scheduled  
7.23 rebasing must be calculated and made available to the legislature by January 15 of each  
7.24 year in which rebasing is scheduled to occur, and must include by hospital the differential  
7.25 in payment rates compared to the individual hospital's costs.

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

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

9.11 methods and allowable costs of the Medicare program in effect during the base year or  
9.12 years.

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

9.18 (h) Effective for discharges occurring on or after July 1, 2017, and every two years  
9.19 thereafter, payment rates under this section shall be rebased to reflect only those changes  
9.20 in hospital costs between the existing base year or years and the next base year or years. In  
9.21 any year that inpatient claims volume falls below the threshold required to ensure a  
9.22 statistically valid sample of claims, the commissioner may combine claims data from two  
9.23 consecutive years to serve as the base year. Years in which inpatient claims volume is  
9.24 reduced or altered due to a pandemic or other public health emergency shall not be used as  
9.25 a base year or part of a base year if the base year includes more than one year. Changes in  
9.26 costs between base years shall be measured using the lower of the hospital cost index defined  
9.27 in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per  
9.28 claim. The commissioner shall establish the base year for each rebasing period considering  
9.29 the most recent year or years for which filed Medicare cost reports are available, except  
9.30 that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019.  
9.31 The estimated change in the average payment per hospital discharge resulting from a  
9.32 scheduled rebasing must be calculated and made available to the legislature by January 15  
9.33 of each year in which rebasing is scheduled to occur, and must include by hospital the  
9.34 differential in payment rates compared to the individual hospital's costs.

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

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

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

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

8.12 (j) Effective for discharges occurring on or after July 1, 2023, payment rates under this  
8.13 section must be rebased to reflect those changes in hospital costs between the existing base  
8.14 year or years and one year prior to the rate year. In any year that inpatient claims volume  
8.15 falls below the threshold required to ensure a statistically valid sample of claims, the  
8.16 commissioner may combine claims data from two consecutive years to serve as the base  
8.17 year. Years in which inpatient claims volume is reduced or altered due to a pandemic or  
8.18 other public health emergency must not be used as a base year or part of a base year if the  
8.19 base year includes more than one year. Changes in costs between the base year or years and  
8.20 one year prior to the rate year must be measured using the hospital cost index defined in  
8.21 subdivision 1, paragraph (a). The commissioner must establish the base year for each rebasing  
8.22 period considering the most recent year or years for which filed Medicare cost reports are  
8.23 available. The estimated change in the average payment per hospital discharge resulting  
8.24 from a scheduled rebasing must be calculated and made available to the legislature by  
8.25 January 15 of each year in which rebasing is scheduled to occur, and must include the  
8.26 differential in payment rates compared to the individual hospital's costs by hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.12 (6) geographic location.

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

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

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

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

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

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

11.3 (6) geographic location.

11.4 **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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.13 enrollees in fee-for-service medical assistance. The commissioner shall consider factors  
11.14 including fee-for-service medical assistance utilization rates and payments made for drugs  
11.15 purchased through the 340B drug purchasing program and administered to fee-for-service  
11.16 enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate  
11.17 share hospital limit, or if the hospital qualifies for the alternative payment rate described in  
11.18 subdivision 2e, the commissioner shall make a payment to the hospital that equals the  
11.19 nonfederal share of the amount that exceeds the limit. The total nonfederal share of the  
11.20 amount of the payment adjustment under this paragraph shall not exceed ~~\$1,500,000~~  
11.21 \$10,000,000. The department shall calculate the aggregate difference in payments for  
11.22 outpatient pharmacy claims for members enrolled with medical assistance prepaid health  
11.23 plans reimbursed at the 340B rate as compared to the non-340B rate, as defined in section  
11.24 256B.0625. The department shall report the results to the chairs and ranking minority  
11.25 members of the legislative committees with jurisdiction over medical assistance hospital  
11.26 reimbursement no later than January 1 for the previous fiscal year.

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

11.33 basis.

12.1               (b) For admissions occurring on or after April 1, 1995, a long-term hospital as designated

12.2 by Medicare that does not have admissions in the base year shall have inpatient rates

12.3 established at the average of other hospitals with the same designation. For subsequent

12.4 rate-setting periods in which base years are updated, the hospital's base year shall be the

12.5 first Medicare cost report filed with the long-term hospital designation and shall remain in

12.6 effect until it falls within the same period as other hospitals.

12.7               (c) For admissions occurring on or after July 1, 2023, long-term hospitals must be paid

12.8 the higher of a per diem amount computed using the methodology described in subdivision

12.9 2b, paragraph (i), or the per diem rate as of July 1, 2021.

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

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

12.12 read:

12.13               Subd. 31. **Long-acting reversible contraceptives.** (a) The commissioner must provide

12.14 separate reimbursement to hospitals for long-acting reversible contraceptives provided

12.15 immediately postpartum in the inpatient hospital setting. This payment must be in addition

73.22 enrollees in fee-for-service medical assistance. The commissioner shall consider factors

73.23 including fee-for-service medical assistance utilization rates and payments made for drugs

73.24 purchased through the 340B drug purchasing program and administered to fee-for-service

73.25 enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate

73.26 share hospital limit, or if the hospital qualifies for the alternative payment rate described in

73.27 subdivision 2e, the commissioner shall make a payment to the hospital that equals the

73.28 nonfederal share of the amount that exceeds the limit. The total nonfederal share of the

73.29 amount of the payment adjustment under this paragraph shall not exceed ~~\$1,500,000~~

73.30 \$10,000,000. The commissioner shall calculate the aggregate difference in payments for

73.31 outpatient pharmacy claims for medical assistance enrollees receiving services from a

73.32 managed care or county-based purchasing plan, when reimbursed at the 340B rate as

73.33 compared to the non-340B rate, as specified in section 256B.0625, subdivision 13e. By

73.34 February 1, 2026, the commissioner shall report the results of this calculation for the prior

74.1 fiscal year to the chairs and ranking members of the legislative committees with jurisdiction

74.2 over health care finance and policy.

74.3               **EFFECTIVE DATE.** This section is effective January 1, 2026, or the January 1

74.4 following certification of the modernized pharmacy claims processing system, whichever

74.5 is later. The commissioner of human services shall notify the revisor of statutes when

74.6 certification of the modernized pharmacy claims processing system occurs.

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

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

13.14 basis.

13.15               (b) For admissions occurring on or after April 1, 1995, a long-term hospital as designated

13.16 by Medicare that does not have admissions in the base year shall have inpatient rates

13.17 established at the average of other hospitals with the same designation. For subsequent

13.18 rate-setting periods in which base years are updated, the hospital's base year shall be the

13.19 first Medicare cost report filed with the long-term hospital designation and shall remain in

13.20 effect until it falls within the same period as other hospitals.

13.21               (c) For admissions occurring on or after July 1, 2023, long-term hospitals must be paid

13.22 the higher of a per diem amount computed using the methodology described in subdivision

13.23 2b, paragraph (i), or the per diem rate as of July 1, 2021.

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

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

13.26 read:

13.27               Subd. 31. **Long-acting reversible contraceptives.** (a) The commissioner must provide

13.28 separate reimbursement to hospitals for long-acting reversible contraceptives provided

13.29 immediately postpartum in the inpatient hospital setting. This payment must be in addition

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

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

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

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

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

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

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

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

14.9 (1) eyeglasses;

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

14.13 (3) hearing aids and supplies;

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

14.15 (i) hospital beds;

14.16 (ii) commodes;

14.17 (iii) glide-about chairs;

14.18 (iv) patient lift apparatus;

14.19 (v) wheelchairs and accessories;

14.20 (vi) oxygen administration equipment;

14.21 (vii) respiratory therapy equipment;

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

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

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

14.28 (6) drugs; and

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

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

12.22 Subd. 17. **Adults who were in foster care at the age of 18.** (a) Medical assistance may

12.23 be paid for a person under 26 years of age who was in foster care under the commissioner's

12.24 responsibility on the date of attaining 18 years of age, and who was enrolled in medical

12.25 assistance under the state plan or a waiver of the plan while in foster care, in accordance

12.26 with section 2004 of the Affordable Care Act.

12.27 (b) Beginning July 1, 2023, medical assistance may be paid for a person under 26 years

12.28 of age who was in foster care on the date of attaining 18 years of age and enrolled in another

12.29 state's Medicaid program while in foster care in accordance with the Substance Use-Disorder

12.30 Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities

12.31 Act of 2018. Public Law 115-271, section 1002.

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

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

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

13.3 services.

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

13.5 ~~services:~~

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

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

13.8 ~~(3) limited exams;~~

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

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

13.11 ~~(6) panoramic x-rays, limited to one every five years except (1) when medically necessary~~

13.12 ~~for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once~~

15.1 (b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not

15.2 affect contract payments under this subdivision unless specifically identified.

15.3 (c) The commissioner may not utilize volume purchase through competitive bidding

15.4 and negotiation under the provisions of chapter 16C for special transportation services or

15.5 incontinence products and related supplies.

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

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

15.8 Subd. 17. **Adults who were in foster care at the age of 18.** (a) Medical assistance may

15.9 be paid for a person under 26 years of age who was in foster care under the commissioner's

15.10 responsibility on the date of attaining 18 years of age, and who was enrolled in medical

15.11 assistance under the state plan or a waiver of the plan while in foster care, in accordance

15.12 with section 2004 of the Affordable Care Act.

15.13 (b) Beginning July 1, 2023, medical assistance may be paid for a person under 26 years

15.14 of age who was in foster care on the date of attaining 18 years of age and enrolled in another

15.15 state's Medicaid program while in foster care in accordance with the Substance Use-Disorder

15.16 Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities

15.17 Act of 2018. Public Law 115-271, section 1002.

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

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

15.20 Subd. 3a. ~~Sex reassignment surgery~~ **Gender-affirming services.** ~~Sex reassignment~~

15.21 ~~surgery is not covered.~~ Medical assistance covers gender-affirming services.

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

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

15.24 services.

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

15.26 ~~services:~~

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

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

15.29 ~~(3) limited exams;~~

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

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

16.2 ~~(6) panoramic x-rays, limited to one every five years except (1) when medically necessary~~

16.3 ~~for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once~~

13.13 every two years for patients who cannot cooperate for intraoral film due to a developmental  
13.14 disability or medical condition that does not allow for intraoral film placement;  
13.15 (7) prophylaxis, limited to one per year;  
13.16 (8) application of fluoride varnish, limited to one per year;  
13.17 (9) posterior fillings, all at the amalgam rate;  
13.18 (10) anterior fillings;  
13.19 (11) endodontics, limited to root canals on the anterior and premolars only;  
13.20 (12) removable prostheses, each dental arch limited to one every six years;  
13.21 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;  
13.22 (14) palliative treatment and sedative fillings for relief of pain;  
13.23 (15) full-mouth debridement, limited to one every five years; and  
13.24 (16) nonsurgical treatment for periodontal disease, including sealing and root planing  
13.25 once every two years for each quadrant, and routine periodontal maintenance procedures.  
13.26 (e) In addition to the services specified in paragraph (b), medical assistance covers the  
13.27 following services for adults, if provided in an outpatient hospital setting or freestanding  
13.28 ambulatory surgical center as part of outpatient dental surgery:  
13.29 (1) periodontics, limited to periodontal sealing and root planing once every two years;  
14.1 (2) general anesthesia; and  
14.2 (3) full-mouth survey once every five years.  
14.3 (d) Medical assistance covers medically necessary dental services for children and  
14.4 pregnant women. (b) The following guidelines apply to dental services:  
14.5 (1) posterior fillings are paid at the amalgam rate;  
14.6 (2) application of sealants are covered once every five years per permanent molar for  
14.7 children only; and  
14.8 (3) application of fluoride varnish is covered once every six months; and.  
14.9 (4) orthodontia is eligible for coverage for children only.  
14.10 (e) (c) In addition to the services specified in paragraphs paragraph (b) and (e), medical  
14.11 assistance covers the following services for adults:  
14.12 (1) house calls or extended care facility calls for on-site delivery of covered services;  
14.13 (2) behavioral management when additional staff time is required to accommodate  
14.14 behavioral challenges and sedation is not used;

16.4 every two years for patients who cannot cooperate for intraoral film due to a developmental  
16.5 disability or medical condition that does not allow for intraoral film placement;  
16.6 (7) prophylaxis, limited to one per year;  
16.7 (8) application of fluoride varnish, limited to one per year;  
16.8 (9) posterior fillings, all at the amalgam rate;  
16.9 (10) anterior fillings;  
16.10 (11) endodontics, limited to root canals on the anterior and premolars only;  
16.11 (12) removable prostheses, each dental arch limited to one every six years;  
16.12 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;  
16.13 (14) palliative treatment and sedative fillings for relief of pain;  
16.14 (15) full-mouth debridement, limited to one every five years; and  
16.15 (16) nonsurgical treatment for periodontal disease, including sealing and root planing  
16.16 once every two years for each quadrant, and routine periodontal maintenance procedures.  
16.17 (e) In addition to the services specified in paragraph (b), medical assistance covers the  
16.18 following services for adults, if provided in an outpatient hospital setting or freestanding  
16.19 ambulatory surgical center as part of outpatient dental surgery:  
16.20 (1) periodontics, limited to periodontal sealing and root planing once every two years;  
16.21 (2) general anesthesia; and  
16.22 (3) full-mouth survey once every five years.  
16.23 (d) Medical assistance covers medically necessary dental services for children and  
16.24 pregnant women. The following guidelines apply:  
16.25 (1) posterior fillings are paid at the amalgam rate;  
16.26 (2) application of sealants are covered once every five years per permanent molar for  
16.27 children only;  
16.28 (3) application of fluoride varnish is covered once every six months; and  
16.29 (4) orthodontia is eligible for coverage for children only.  
17.1 (e) (b) In addition to the services specified in paragraphs (b) and (e) paragraph (a),  
17.2 medical assistance covers the following services for adults:  
17.3 (1) house calls or extended care facility calls for on-site delivery of covered services;  
17.4 (2) behavioral management when additional staff time is required to accommodate  
17.5 behavioral challenges and sedation is not used;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16.4 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable  
16.5 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and  
16.6 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible  
16.7 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and  
16.8 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these  
16.9 individuals, medical assistance may cover drugs from the drug classes listed in United States  
16.10 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to  
16.11 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall  
16.12 not be covered.

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

16.17 (g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal  
16.18 contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section  
16.19 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a  
16.20 licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists  
16.21 used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed  
16.22 pharmacist in accordance with section 151.37, subdivision 16.

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

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

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

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

17.3 Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations  
 17.4 from professional medical associations and professional pharmacy associations, and consumer  
 17.5 groups shall designate a Formulary Committee to carry out duties as described in subdivisions  
 17.6 13 to 13g. The Formulary Committee shall be comprised of ~~four~~ at least five licensed  
 17.7 physicians actively engaged in the practice of medicine in Minnesota, one of whom ~~must~~  
 17.8 ~~be actively engaged in the treatment of persons with mental illness~~ is an actively practicing  
 17.9 psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one  
 17.10 of whom specializes in pediatrics, and one of whom actively treats persons with disabilities;  
 17.11 at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota,  
 17.12 one of whom practices outside the metropolitan counties listed in section 473.121, subdivision  
 17.13 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision  
 17.14 4, and one of whom is a practicing hospital pharmacist; ~~and one~~ at least four consumer  
 17.15 ~~representative~~ representatives, all of whom must have a personal or professional connection  
 17.16 to medical assistance; and one representative designated by the Minnesota Rare Disease  
 17.17 Advisory Council established under section 256.4835; the remainder to be made up of health  
 17.18 care professionals who are licensed in their field and have recognized knowledge in the  
 17.19 clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs.  
 17.20 Members of the Formulary Committee shall not be employed by the Department of Human  
 17.21 Services, but the committee shall be staffed by an employee of the department who shall  
 17.22 serve as an ex officio, nonvoting member of the committee. The department's medical  
 17.23 director shall also serve as an ex officio, nonvoting member for the committee. Committee  
 17.24 members shall serve three-year terms and may be reappointed once by the commissioner.  
 17.25 The committee members shall vote on a chair from among their membership. The chair  
 17.26 shall preside over all committee meetings. The Formulary Committee shall meet at least  
 17.27 ~~twice~~ four times per year. The commissioner may require more frequent Formulary  
 17.28 Committee meetings as needed. An honorarium of \$100 per meeting and reimbursement  
 17.29 for mileage shall be paid to each committee member in attendance. The Formulary Committee  
 17.30 is subject to the Open Meeting Law under chapter 13D. The Formulary Committee expires  
 17.31 June 30, 2023 2027.

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

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

17.19 Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations  
 17.20 from professional medical associations and professional pharmacy associations, and consumer  
 17.21 groups shall designate a Formulary Committee to carry out duties as described in subdivisions  
 17.22 13 to 13g. The Formulary Committee shall be comprised of ~~four~~ at least five licensed  
 17.23 physicians actively engaged in the practice of medicine in Minnesota, one of whom ~~must~~  
 17.24 ~~be actively engaged in the treatment of persons with mental illness~~ is an actively practicing  
 17.25 psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one  
 17.26 of whom specializes in pediatrics, and one of whom actively treats persons with disabilities;  
 17.27 at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota,  
 17.28 one of whom practices outside the metropolitan counties listed in section 473.121, subdivision  
 17.29 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision  
 17.30 4, and one of whom is a practicing hospital pharmacist; ~~and one~~ at least four consumer  
 17.31 ~~representative~~ representatives, all of whom must have a personal or professional connection  
 17.32 to medical assistance; and one representative designated by the Minnesota Rare Disease  
 17.33 Advisory Council established under section 256.4835; the remainder to be made up of health  
 18.1 care professionals who are licensed in their field and have recognized knowledge in the  
 18.2 clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs.  
 18.3 Members of the Formulary Committee shall not be employed by the Department of Human  
 18.4 Services, but the committee shall be staffed by an employee of the department who shall  
 18.5 serve as an ex officio, nonvoting member of the committee. The department's medical  
 18.6 director shall also serve as an ex officio, nonvoting member for the committee. Committee  
 18.7 members shall serve three-year terms and may be reappointed by the commissioner. The  
 18.8 Formulary Committee shall meet at least ~~twice~~ once per year. The commissioner may require  
 18.9 more frequent Formulary Committee meetings as needed. An honorarium of \$100 per  
 18.10 meeting and reimbursement for mileage shall be paid to each committee member in  
 18.11 attendance. Notwithstanding section 15.059, subdivision 6, the Formulary Committee expires  
 18.12 June 30, 2023 does not expire.



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

18.15 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall  
18.16 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the  
18.17 usual and customary price charged to the public. The usual and customary price means the  
18.18 lowest price charged by the provider to a patient who pays for the prescription by cash,  
18.19 check, or charge account and includes prices the pharmacy charges to a patient enrolled in  
18.20 a prescription savings club or prescription discount club administered by the pharmacy or  
18.21 pharmacy chain. The amount of payment basis must be reduced to reflect all discount  
18.22 amounts applied to the charge by any third-party provider/insurer agreement or contract for  
18.23 submitted charges to medical assistance programs. The net submitted charge may not be  
18.24 greater than the patient liability for the service. The professional dispensing fee shall be  
18.25 \$10.77 for prescriptions filled with legend drugs meeting the definition of "covered outpatient  
18.26 drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee  
18.27 for intravenous solutions that must be compounded by the pharmacist shall be \$10.77 per  
18.28 claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs  
18.29 meeting the definition of covered outpatient drugs shall be \$10.77 for dispensed quantities  
18.30 equal to or greater than the number of units contained in the manufacturer's original package.  
18.31 The professional dispensing fee shall be prorated based on the percentage of the package  
18.32 dispensed when the pharmacy dispenses a quantity less than the number of units contained  
18.33 in the manufacturer's original package. The pharmacy dispensing fee for prescribed  
18.34 over-the-counter drugs not meeting the definition of covered outpatient drugs shall be \$3.65  
18.35 for quantities equal to or greater than the number of units contained in the manufacturer's  
19.1 original package and shall be prorated based on the percentage of the package dispensed  
19.2 when the pharmacy dispenses a quantity less than the number of units contained in the  
19.3 manufacturer's original package. The National Average Drug Acquisition Cost (NADAC)  
19.4 shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is  
19.5 not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition  
19.6 cost minus two percent. The ingredient cost of a drug for a provider participating in the  
19.7 federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling  
19.8 price established by the Health Resources and Services Administration or NADAC,  
19.9 whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price  
19.10 for a drug or biological to wholesalers or direct purchasers in the United States, not including  
19.11 prompt pay or other discounts, rebates, or reductions in price, for the most recent month for  
19.12 which information is available, as reported in wholesale price guides or other publications  
19.13 of drug or biological pricing data. The maximum allowable cost of a multisource drug may  
19.14 be set by the commissioner and it shall be comparable to the actual acquisition cost of the  
19.15 drug product and no higher than the NADAC of the generic product. Establishment of the  
19.16 amount of payment for drugs shall not be subject to the requirements of the Administrative  
19.17 Procedure Act.

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

19.20 packaging system meeting the packaging standards set forth in Minnesota Rules, part  
19.21 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ  
19.22 retrospective billing for prescription drugs dispensed to long-term care facility residents. A  
19.23 retrospectively billing pharmacy must submit a claim only for the quantity of medication  
19.24 used by the enrolled recipient during the defined billing period. A retrospectively billing  
19.25 pharmacy must use a billing period not less than one calendar month or 30 days.

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

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

20.3 (e) The basis for determining the amount of payment for drugs administered in an  
20.4 outpatient setting shall be the lower of the usual and customary cost submitted by the  
20.5 provider, 106 percent of the average sales price as determined by the United States  
20.6 Department of Health and Human Services pursuant to title XVIII, section 1847a of the  
20.7 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost  
20.8 set by the commissioner. If average sales price is unavailable, the amount of payment must  
20.9 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition  
20.10 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.  
20.11 The commissioner shall discount the payment rate for drugs obtained through the federal  
20.12 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an  
20.13 outpatient setting shall be made to the administering facility or practitioner. A retail or  
20.14 specialty pharmacy dispensing a drug for administration in an outpatient setting is not  
20.15 eligible for direct reimbursement.

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

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

18.2               Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and

18.3 recommend drugs which require prior authorization. The Formulary Committee shall

18.4 establish general criteria to be used for the prior authorization of brand-name drugs for

18.5 which generically equivalent drugs are available, but the committee is not required to review

18.6 each brand-name drug for which a generically equivalent drug is available.

20.27 require complex care. The commissioner shall consult with the Formulary Committee to

20.28 develop a list of specialty pharmacy products subject to maximum allowable cost

20.29 reimbursement. In consulting with the Formulary Committee in developing this list, the

20.30 commissioner shall take into consideration the population served by specialty pharmacy

20.31 products, the current delivery system and standard of care in the state, and access to care

20.32 issues. The commissioner shall have the discretion to adjust the maximum allowable cost

20.33 to prevent access to care issues.

20.34               (g) Home infusion therapy services provided by home infusion therapy pharmacies must

20.35 be paid at rates according to subdivision 8d.

21.1               (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey

21.2 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient

21.3 drugs under medical assistance. The commissioner shall ensure that the vendor has prior

21.4 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the

21.5 department to dispense outpatient prescription drugs to fee-for-service members must

21.6 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under

21.7 section 256B.064 for failure to respond. The commissioner shall require the vendor to

21.8 measure a single statewide cost of dispensing for specialty prescription drugs and a single

21.9 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies

21.10 to measure the mean, mean weighted by total prescription volume, mean weighted by

21.11 medical assistance prescription volume, median, median weighted by total prescription

21.12 volume, and median weighted by total medical assistance prescription volume. The

21.13 commissioner shall post a copy of the final cost of dispensing survey report on the

21.14 department's website. The initial survey must be completed no later than January 1, 2021,

21.15 and repeated every three years. The commissioner shall provide a summary of the results

21.16 of each cost of dispensing survey and provide recommendations for any changes to the

21.17 dispensing fee to the chairs and ranking members of the legislative committees with

21.18 jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section

21.19 256.01, subdivision 42, this paragraph does not expire.

21.20               (i) The commissioner shall increase the ingredient cost reimbursement calculated in

21.21 paragraphs (a) and (f) by 1.8 percent for prescription and nonprescription drugs subject to

21.22 the wholesale drug distributor tax under section 295.52.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19.15 ~~(e)~~ (f) Notwithstanding this subdivision, the commissioner may automatically require  
19.16 prior authorization, for a period not to exceed 180 days, for any drug that is approved by  
19.17 the United States Food and Drug Administration on or after July 1, 2005. The 180-day  
19.18 period begins no later than the first day that a drug is available for shipment to pharmacies  
19.19 within the state. The Formulary Committee shall recommend to the commissioner general  
19.20 criteria to be used for the prior authorization of the drugs, but the committee is not required  
19.21 to review each individual drug. In order to continue prior authorizations for a drug after the  
19.22 180-day period has expired, the commissioner must follow the provisions of this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25.1 (i) general social services and administrative costs;

25.2 (ii) retail pharmacy;

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

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

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

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

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

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

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

27.19 (i) general social services and administrative costs;

27.20 (ii) retail pharmacy;

25.3 (iii) patient incentives, food, housing assistance, and utility assistance;  
25.4 (iv) external lab and x-ray;  
25.5 (v) navigation services;  
25.6 (vi) health care taxes;  
25.7 (vii) advertising, public relations, and marketing;  
25.8 (viii) office entertainment costs, food, alcohol, and gifts;  
25.9 (ix) contributions and donations;  
25.10 (x) bad debts or losses on awards or contracts;  
25.11 (xi) fines, penalties, damages, or other settlements;  
25.12 (xii) fundraising, investment management, and associated administrative costs;  
25.13 (xiii) research and associated administrative costs;  
25.14 (xiv) nonpaid workers;  
25.15 (xv) lobbying;  
25.16 (xvi) scholarships and student aid; and  
25.17 (xvii) nonmedical assistance covered services;  
25.18 (4) the commissioner shall review the list of nonallowable costs in the years between  
25.19 the rebasing process established in clause (5), in consultation with the Minnesota Association  
25.20 of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall  
25.21 publish the list and any updates in the Minnesota health care programs provider manual;  
25.22 (5) the initial applicable base year organization encounter rates for FQHCs and rural  
25.23 health clinics shall be computed for services delivered on or after January 1, 2021, and:  
25.24 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports  
25.25 from 2017 and 2018;  
25.26 (ii) must be according to current applicable Medicare cost principles as applicable to  
25.27 FQHCs and rural health clinics without the application of productivity screens and upper  
25.28 payment limits or the Medicare prospective payment system FQHC aggregate mean upper  
25.29 payment limit;  
26.1 (iii) must be subsequently rebased every two years thereafter using the Medicare cost  
26.2 reports that are three and four years prior to the rebasing year. Years in which organizational  
26.3 cost or claims volume is reduced or altered due to a pandemic, disease, or other public health  
26.4 emergency shall not be used as part of a base year when the base year includes more than  
26.5 one year. The commissioner may use the Medicare cost reports of a year unaffected by a

27.21 (iii) patient incentives, food, housing assistance, and utility assistance;  
27.22 (iv) external lab and x-ray;  
27.23 (v) navigation services;  
27.24 (vi) health care taxes;  
27.25 (vii) advertising, public relations, and marketing;  
27.26 (viii) office entertainment costs, food, alcohol, and gifts;  
27.27 (ix) contributions and donations;  
27.28 (x) bad debts or losses on awards or contracts;  
27.29 (xi) fines, penalties, damages, or other settlements;  
27.30 (xii) fundraising, investment management, and associated administrative costs;  
28.1 (xiii) research and associated administrative costs;  
28.2 (xiv) nonpaid workers;  
28.3 (xv) lobbying;  
28.4 (xvi) scholarships and student aid; and  
28.5 (xvii) nonmedical assistance covered services;  
28.6 (4) the commissioner shall review the list of nonallowable costs in the years between  
28.7 the rebasing process established in clause (5), in consultation with the Minnesota Association  
28.8 of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall  
28.9 publish the list and any updates in the Minnesota health care programs provider manual;  
28.10 (5) the initial applicable base year organization encounter rates for FQHCs and rural  
28.11 health clinics shall be computed for services delivered on or after January 1, 2021, and:  
28.12 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports  
28.13 from 2017 and 2018;  
28.14 (ii) must be according to current applicable Medicare cost principles as applicable to  
28.15 FQHCs and rural health clinics without the application of productivity screens and upper  
28.16 payment limits or the Medicare prospective payment system FQHC aggregate mean upper  
28.17 payment limit;  
28.18 (iii) must be subsequently rebased every two years thereafter using the Medicare cost  
28.19 reports that are three and four years prior to the rebasing year. Years in which organizational  
28.20 cost or claims volume is reduced or altered due to a pandemic, disease, or other public health  
28.21 emergency shall not be used as part of a base year when the base year includes more than  
28.22 one year. The commissioner may use the Medicare cost reports of a year unaffected by a

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

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

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

26.11 (6) the commissioner shall annually inflate the applicable organization encounter rates  
 26.12 for FQHCs and rural health clinics from the base year payment rate to the effective date by  
 26.13 using the CMS FQHC Market Basket inflator established under United States Code, title  
 26.14 42, section 1395m(o), less productivity;

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

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

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

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

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

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

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

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

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

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

28.28 (6) the commissioner shall annually inflate the applicable organization encounter rates  
 28.29 for FQHCs and rural health clinics from the base year payment rate to the effective date by  
 28.30 using the CMS FQHC Market Basket inflator established under United States Code, title  
 28.31 42, section 1395m(o), less productivity;

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

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

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

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

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

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

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

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

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

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

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

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

28.7 **EFFECTIVE DATE.** This section is effective January 1, 2026, or upon federal approval,  
28.8 whichever is later. The commissioner of human services shall notify the revisor of statutes  
28.9 when federal approval is obtained.

28.10 Sec. 16. Minnesota Statutes 2022, section 256B.0625, subdivision 31, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29.2 (1) can withstand repeated use;

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

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

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

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

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

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

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

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

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

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

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

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

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

31.20 (1) can withstand repeated use;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

30.30 **EFFECTIVE DATE.** This section is effective January 1, 2026, or upon federal approval,  
30.31 whichever is later. The commissioner of human services shall notify the revisor of statutes  
30.32 when federal approval is obtained.

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

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

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

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

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

33.17 **EFFECTIVE DATE.** This section is effective January 1, 2026, or upon federal approval,  
33.18 whichever is later. The commissioner of human services shall notify the revisor of statutes  
33.19 when federal approval is obtained.

33.20 Sec. 23. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision  
33.21 to read:

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

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

33.31 (1) mental health practitioners under section 245.462, subdivision 17;  
33.32 (2) mental health professionals under section 245.462, subdivision 18;  
33.33 (3) mental health certified peer specialists under section 256B.0615;  
34.1 (4) alcohol and drug counselors licensed under chapter 148F;

- 34.2 (5) recovery peers as defined in section 245F.02, subdivision 21;
- 34.3 (6) certified tobacco treatment specialists;
- 34.4 (7) community health workers;
- 34.5 (8) physicians;
- 34.6 (9) physician assistants;
- 34.7 (10) advanced practice registered nurses; or
- 34.8 (11) other licensed or nonlicensed professionals or paraprofessionals with training in
- 34.9 providing tobacco and nicotine cessation education and counseling services.
- 34.10 (c) Medical assistance covers telephone cessation counseling services provided through
- 34.11 a quitline. Notwithstanding section 256B.0625, subdivision 3b, quitline services may be
- 34.12 provided through audio-only communications. The commissioner of human services may
- 34.13 utilize volume purchasing for quitline services consistent with section 256B.04, subdivision
- 34.14 14.
- 34.15 (d) Medical assistance must cover all prescription and over-the-counter pharmacotherapy
- 34.16 drugs approved by the United States Food and Drug Administration for cessation of tobacco
- 34.17 and nicotine use or treatment of tobacco and nicotine dependence, and that are subject to a
- 34.18 Medicaid drug rebate agreement.
- 34.19 (e) Services covered under this subdivision may be provided by telemedicine.
- 34.20 (f) The commissioner must not:
- 34.21 (1) restrict or limit the type, duration, or frequency of tobacco and nicotine cessation
- 34.22 services;
- 34.23 (2) prohibit the simultaneous use of multiple cessation services, including but not limited
- 34.24 to simultaneous use of counseling and drugs;
- 34.25 (3) require counseling before receiving drugs or as a condition of receiving drugs;
- 34.26 (4) limit pharmacotherapy drug dosage amounts for a dosing regimen for treatment of
- 34.27 a medically accepted indication as defined in United States Code, title 14, section
- 34.28 1396r-8(K)(6); limit dosing frequency; or impose duration limits;
- 34.29 (5) prohibit simultaneous use of multiple drugs, including prescription and
- 34.30 over-the-counter drugs;
- 35.1 (6) require or authorize step therapy; or
- 35.2 (7) require or utilize prior authorization for any tobacco and nicotine cessation services
- 35.3 and drugs covered under this subdivision.

31.9       Sec. 19. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision  
31.10 to read:  
  
31.11       Subd. 69. **Recuperative care services.** Medical assistance covers recuperative care  
31.12 services according to section 256B.0701.

35.4       **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  
  
35.5       Sec. 24. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision  
35.6 to read:  
  
35.7       Subd. 69. **Recuperative care services.** (a) Medical assistance covers recuperative care  
35.8 services provided in a setting that meets the requirements in paragraph (b) for recipients  
35.9 who meet the eligibility requirements in paragraph (c). For purposes of this subdivision,  
35.10 "recuperative care" means a model of care that prevents hospitalization or that provides  
35.11 postacute medical care and support services for recipients experiencing homelessness who  
35.12 are too ill or frail to recover from a physical illness or injury while living in a shelter or are  
35.13 otherwise unhoused but who are not sick enough to be hospitalized, or remain hospitalized,  
35.14 or to need other levels of care.  
  
35.15       (b) Recuperative care may be provided in any setting, including but not limited to  
35.16 homeless shelters, congregate care settings, single-room occupancy settings, or supportive  
35.17 housing, so long as the provider of recuperative care or provider of housing is able to provide  
35.18 to the recipient within the designated setting, at a minimum:  
  
35.19       (1) 24-hour access to a bed and bathroom;  
35.20       (2) access to three meals a day;  
35.21       (3) availability to environmental services;  
35.22       (4) access to a telephone;  
35.23       (5) a secure place to store belongings; and  
35.24       (6) staff available within the setting to provide a wellness check as needed, but at a  
35.25 minimum at least once every 24 hours.  
  
35.26       (c) To be eligible for this covered service, a recipient must:  
35.27       (1) be 21 years of age or older;  
35.28       (2) be experiencing homelessness;  
35.29       (3) be in need of short-term acute medical care for a period of no more than 60 days;  
36.1       (4) meet clinical criteria, as established by the commissioner, that indicates that the  
36.2 recipient is in need of recuperative care; and  
  
36.3       (5) not have behavioral health needs that are greater than what can be managed by the  
36.4 provider within the setting.  
  
36.5       (d) Payment for recuperative care shall consist of two components. The first component  
36.6 must be for the services provided to the member and is a bundled daily per diem payment

36.7 of at least \$300 per day. The second component must be for the facility costs and must be  
 36.8 paid using state funds equivalent to the amount paid as the medical assistance room and  
 36.9 board rate and annual adjustments. The eligibility standards in chapter 256I shall not apply.  
 36.10 The second component is only paid when the first component is paid to a provider. Providers  
 36.11 may opt to only be reimbursed for the first component. A provider under this subdivision  
 36.12 means a recuperative care provider and is defined by the standards established by the National  
 36.13 Institute for Medical Respite Care. Services provided within the bundled payment may  
 36.14 include but are not limited to:  
 36.15 (1) basic nursing care, including:  
 36.16 (i) monitoring a patient's physical health and pain level;  
 36.17 (ii) providing wound care;  
 36.18 (iii) medication support;  
 36.19 (iv) patient education;  
 36.20 (v) immunization review and update; and  
 36.21 (vi) establishing clinical goals for the recuperative care period and discharge plan;  
 36.22 (2) care coordination, including:  
 36.23 (i) initial assessment of medical, behavioral, and social needs;  
 36.24 (ii) development of a care plan;  
 36.25 (iii) support and referral assistance for legal services, housing, community social services,  
 36.26 case management, health care benefits, health and other eligible benefits, and transportation  
 36.27 needs and services; and  
 36.28 (iv) monitoring and follow-up to ensure that the care plan is effectively implemented to  
 36.29 address the medical, behavioral, and social needs;  
 36.30 (3) basic behavioral needs, including counseling and peer support, that can be provided  
 36.31 in this recuperative care setting; and  
 37.1 (4) services provided by a community health worker as defined under subdivision 49.  
 37.2 (e) Before a recipient is discharged from a recuperative care setting, the provider must  
 37.3 ensure that the recipient's acute medical condition is stabilized or that the recipient is being  
 37.4 discharged to a setting that is able to meet that recipient's needs.  
 37.5 (f) If a recipient is temporarily absent due to an admission at a residential behavioral  
 37.6 health facility, inpatient hospital, or nursing facility for a period of time exceeding the limits  
 37.7 described in paragraph (d), the agency may request in a format prescribed by the

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

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

31.15 to read:

31.16 Subd. 70. **Coverage of services for the diagnosis, monitoring, and treatment of rare**

31.17 **diseases.** (a) Medical assistance covers services related to the diagnosis, monitoring, and

31.18 treatment of a rare disease or condition. Medical assistance coverage for these services must

31.19 meet the requirements in section 62Q.451.

31.20 (b) Coverage for a service must not be denied solely on the basis that it was provided

31.21 by, referred for, or ordered by an out-of-network provider.

31.22 (c) Any prior authorization requirements for a service that is provided by, referred for,

31.23 or ordered by an out-of-network provider must be the same as any prior authorization

31.24 requirements for a service that is provided by, referred for, or ordered by an in-network

31.25 provider.

31.26 (d) Nothing in this subdivision requires a managed care or county-based purchasing plan

31.27 to provide coverage for a service that is not covered under medical assistance.

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

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

32.2 to read:

32.3 Subd. 71. **Coverage and payment for pharmacy services.** (a) Medical assistance covers

32.4 medical treatment or services provided by a licensed pharmacist, to the extent the medical

32.5 treatment or services are within the pharmacist's scope of practice, if medical assistance

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

37.9 discharged.

37.10 (g) The commissioner shall submit an initial report to the chairs and ranking minority

37.11 members of the legislative committees with jurisdiction over health and human services

37.12 finance and policy by February 1, 2025, and a final report by February 1, 2027, on coverage

37.13 of recuperative care services. The reports must include but are not limited to:

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

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

37.16 hospitalizations;

37.17 (3) follow-up information, if available, on whether recipients' hospital visits decreased

37.18 since recuperative care services were provided compared to before the services were

37.19 provided; and

37.20 (4) any other information that can be used to determine the effectiveness of the program

37.21 and its funding, including recommendations for improvements to the program.

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

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

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

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

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

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

32.21 (1) children under the age of 21;

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

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

32.26 (4) recipients receiving hospice care;

32.27 (5) 100 percent federally funded services provided by an Indian health service;

32.28 (6) emergency services;

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

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

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

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

33.7 (11) American Indians who meet the requirements in Code of Federal Regulations, title  
33.8 42, sections 447.51 and 447.56;

33.9 (12) persons needing treatment for breast or cervical cancer as described under section  
33.10 256B.057, subdivision 10; ~~and~~

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

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

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

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

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

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

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

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

34.3 (1) 24-hour access to a bed and bathroom;

34.4 (2) access to three meals a day;

34.5 (3) availability to environmental services;

34.6 (4) access to a telephone;

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

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

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

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

35.19 (1) 24-hour access to a bed and bathroom;

35.20 (2) access to three meals a day;

35.21 (3) availability to environmental services;

35.22 (4) access to a telephone;

34.7       (5) a secure place to store belongings; and

34.8       (6) staff available within the setting to provide a wellness check as needed, but at a

34.9       minimum, at least once every 24 hours.

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

34.11      (1) be 21 years of age or older;

34.12      (2) be experiencing homelessness;

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

34.14      (4) meet clinical criteria, as established by the commissioner, that indicates that the

34.15       recipient needs recuperative care; and

34.16      (5) not have behavioral health needs that are greater than what can be managed by the

34.17       provider within the setting.

34.18      Subd. 4. **Total payment rates.** Total payment rates for recuperative care consist of the

34.19       recuperative care services rate and the recuperative care facility rate.

34.20      Subd. 5. **Recuperative care services rate.** The recuperative care services rate is for the

34.21       services provided to the recipient and must be a bundled daily per diem payment of at least

34.22       \$300 per day. Services provided within the bundled payment may include but are not limited

34.23       to:

34.24      (1) basic nursing care, including:

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

34.26      (ii) providing wound care;

34.27      (iii) medication support;

35.23      (5) a secure place to store belongings; and

35.24      (6) staff available within the setting to provide a wellness check as needed, but at a

35.25       minimum at least once every 24 hours.

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

35.27      (1) be 21 years of age or older;

35.28      (2) be experiencing homelessness;

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

36.1      (4) meet clinical criteria, as established by the commissioner, that indicates that the

36.2       recipient is in need of recuperative care; and

36.3      (5) not have behavioral health needs that are greater than what can be managed by the

36.4       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.

36.5      (d) Payment for recuperative care shall consist of two components. The first component

36.6       must be for the services provided to the member and is a bundled daily per diem payment

36.7       of at least \$300 per day. The second component must be for the facility costs and must be

36.8       paid using state funds equivalent to the amount paid as the medical assistance room and

36.9       board rate and annual adjustments. The eligibility standards in chapter 256I shall not apply.

36.10      The second component is only paid when the first component is paid to a provider. Providers

36.11      may opt to only be reimbursed for the first component. A provider under this subdivision

36.12      means a recuperative care provider and is defined by the standards established by the National

36.13      Institute for Medical Respite Care. Services provided within the bundled payment may

36.14      include but are not limited to:

36.15      (1) basic nursing care, including:

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

36.17      (ii) providing wound care;

36.18      (iii) medication support;



34.28 (iv) patient education;  
34.29 (v) immunization review and update; and  
35.1 (vi) establishing clinical goals for the recuperative care period and discharge plan;  
35.2 (2) care coordination, including:  
35.3 (i) initial assessment of medical, behavioral, and social needs;  
35.4 (ii) development of a care plan;  
35.5 (iii) support and referral assistance for legal services, housing, community social services,  
35.6 case management, health care benefits, health and other eligible benefits, and transportation  
35.7 needs and services; and  
35.8 (iv) monitoring and follow-up to ensure that the care plan is effectively implemented to  
35.9 address the medical, behavioral, and social needs;  
35.10 (3) basic behavioral needs, including counseling and peer support, that can be provided  
35.11 in this recuperative care setting; and  
35.12 (4) services provided by a community health worker as defined under [section 256B.0625](#),  
35.13 subdivision 49.

35.14 Subd. 6. **Recuperative care facility rate.** (a) The recuperative care facility rate is for  
35.15 facility costs and must be paid from state money in an amount equal to the medical assistance  
35.16 room and board rate at the time the recuperative care services were provided. The eligibility  
35.17 standards in chapter 2561 do not apply to the recuperative care facility rate. The recuperative  
35.18 care facility rate is only paid when the recuperative care services rate is paid to a provider.  
35.19 Providers may opt to only receive the recuperative care services rate.

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

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

36.19 (iv) patient education;  
36.20 (v) immunization review and update; and  
36.21 (vi) establishing clinical goals for the recuperative care period and discharge plan;  
36.22 (2) care coordination, including:  
36.23 (i) initial assessment of medical, behavioral, and social needs;  
36.24 (ii) development of a care plan;  
36.25 (iii) support and referral assistance for legal services, housing, community social services,  
36.26 case management, health care benefits, health and other eligible benefits, and transportation  
36.27 needs and services; and  
36.28 (iv) monitoring and follow-up to ensure that the care plan is effectively implemented to  
36.29 address the medical, behavioral, and social needs;  
36.30 (3) basic behavioral needs, including counseling and peer support, that can be provided  
36.31 in this recuperative care setting; and  
37.1 (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

36.5 (d) Payment for recuperative care shall consist of two components. The first component  
36.6 must be for the services provided to the member and is a bundled daily per diem payment  
36.7 of at least \$300 per day. The second component must be for the facility costs and must be  
36.8 paid using state funds equivalent to the amount paid as the medical assistance room and  
36.9 board rate and annual adjustments. The eligibility standards in chapter 2561 shall not apply.  
36.10 The second component is only paid when the first component is paid to a provider. Providers  
36.11 may opt to only be reimbursed for the first component. A provider under this subdivision  
36.12 means a recuperative care provider and is defined by the standards established by the National  
36.13 Institute for Medical Respite Care. Services provided within the bundled payment may  
36.14 include but are not limited to:

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

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

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

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

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

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

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

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

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

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

36.9 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision  
36.10 3, the commissioner shall determine the fee-for-service outpatient hospital services upper  
36.11 payment limit for nonstate government hospitals. The commissioner shall then determine  
36.12 the amount of a supplemental payment to Hennepin County Medical Center and Regions  
36.13 Hospital for these services that would increase medical assistance spending in this category  
36.14 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.  
36.15 In making this determination, the commissioner shall allot the available increases between  
36.16 Hennepin County Medical Center and Regions Hospital based on the ratio of medical  
36.17 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner  
36.18 shall adjust this allotment as necessary based on federal approvals, the amount of  
36.19 intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,  
36.20 in order to maximize the additional total payments. The commissioner shall inform Hennepin  
36.21 County and Ramsey County of the periodic intergovernmental transfers necessary to match  
36.22 federal Medicaid payments available under this subdivision in order to make supplementary  
36.23 medical assistance payments to Hennepin County Medical Center and Regions Hospital  
36.24 equal to an amount that when combined with existing medical assistance payments to  
36.25 nonstate governmental hospitals would increase total payments to hospitals in this category  
36.26 for outpatient services to the aggregate upper payment limit for all hospitals in this category  
36.27 in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make  
36.28 supplementary payments to Hennepin County Medical Center and Regions Hospital.

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

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

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

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

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

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

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

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

37.24 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision  
37.25 3, the commissioner shall determine the fee-for-service outpatient hospital services upper  
37.26 payment limit for nonstate government hospitals. The commissioner shall then determine  
37.27 the amount of a supplemental payment to Hennepin County Medical Center and Regions  
37.28 Hospital for these services that would increase medical assistance spending in this category  
37.29 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.  
37.30 In making this determination, the commissioner shall allot the available increases between  
37.31 Hennepin County Medical Center and Regions Hospital based on the ratio of medical  
37.32 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner  
38.1 shall adjust this allotment as necessary based on federal approvals, the amount of  
38.2 intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,  
38.3 in order to maximize the additional total payments. The commissioner shall inform Hennepin  
38.4 County and Ramsey County of the periodic intergovernmental transfers necessary to match  
38.5 federal Medicaid payments available under this subdivision in order to make supplementary  
38.6 medical assistance payments to Hennepin County Medical Center and Regions Hospital  
38.7 equal to an amount that when combined with existing medical assistance payments to  
38.8 nonstate governmental hospitals would increase total payments to hospitals in this category  
38.9 for outpatient services to the aggregate upper payment limit for all hospitals in this category  
38.10 in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make  
38.11 supplementary payments to Hennepin County Medical Center and Regions Hospital.

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

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

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

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

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

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

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

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

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

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

39.1 (h) All of the data and funding transactions related to the payments in paragraphs (a) to  
 39.2 (e) shall be between the commissioner and the governmental entities. The commissioner  
 39.3 shall not make payments to governmental entities eligible to receive payments described  
 39.4 in paragraphs (a) to (e) that fail to submit the data needed to compute the payments within  
 39.5 24 months of the initial request from the commissioner.

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

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

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

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

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

40.17 (h) All of the data and funding transactions related to the payments in paragraphs (a) to  
 40.18 (e) shall be between the commissioner and the governmental entities. The commissioner  
 40.19 shall not make payments to governmental entities eligible to receive payments described  
 40.20 in paragraphs (a) to (e) that fail to submit the data needed to compute the payments within  
 40.21 24 months of the initial request from the commissioner.

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

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

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

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

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

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

39.20 (1) persons eligible for medical assistance according to section 256B.055, subdivision  
39.21 1;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

77.3 (1) persons eligible for medical assistance according to section 256B.055, subdivision  
77.4 1;

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

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

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

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

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

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

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

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

40.9 (8) persons eligible for medical assistance according to section 256B.057, subdivision  
40.10 10;

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

40.14 (10) persons who are absent from the state for more than 30 consecutive days but still  
40.15 deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision  
40.16 1, paragraph (b).

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

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

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

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

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

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

77.23 (8) persons eligible for medical assistance according to section 256B.057, subdivision  
77.24 10;

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

77.28 (10) persons who are absent from the state for more than 30 consecutive days but still  
77.29 deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision  
77.30 1, paragraph (b).

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

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

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

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

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

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

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

41.14           Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and

41.15 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner

41.16 may issue separate contracts with requirements specific to services to medical assistance

41.17 recipients age 65 and older.

41.18           (b) A prepaid health plan providing covered health services for eligible persons pursuant

41.19 to chapters 256B and 256L is responsible for complying with the terms of its contract with

41.20 the commissioner. Requirements applicable to managed care programs under chapters 256B

41.21 and 256L established after the effective date of a contract with the commissioner take effect

41.22 when the contract is next issued or renewed.

41.23           (c) The commissioner shall withhold five percent of managed care plan payments under

41.24 this section and county-based purchasing plan payments under section 256B.692 for the

41.25 prepaid medical assistance program pending completion of performance targets. Each

41.26 performance target must be quantifiable, objective, measurable, and reasonably attainable,

41.27 except in the case of a performance target based on a federal or state law or rule. Criteria

41.28 for assessment of each performance target must be outlined in writing prior to the contract

41.29 effective date. Clinical or utilization performance targets and their related criteria must

41.30 consider evidence-based research and reasonable interventions when available or applicable

41.31 to the populations served, and must be developed with input from external clinical experts

41.32 and stakeholders, including managed care plans, county-based purchasing plans, and

41.33 providers. The managed care or county-based purchasing plan must demonstrate, to the

41.34 commissioner's satisfaction, that the data submitted regarding attainment of the performance

42.1 target is accurate. The commissioner shall periodically change the administrative measures

42.2 used as performance targets in order to improve plan performance across a broader range

42.3 of administrative services. The performance targets must include measurement of plan

42.4 efforts to contain spending on health care services and administrative activities. The

42.5 commissioner may adopt plan-specific performance targets that take into account factors

42.6 affecting only one plan, including characteristics of the plan's enrollee population. The

42.7 withheld funds must be returned no sooner than July of the following year if performance

42.8 targets in the contract are achieved. The commissioner may exclude special demonstration

42.9 projects under subdivision 23.

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

42.11           (1) use the assessment and authorization processes, forms, timelines, standards,

42.12 documentation, and data reporting requirements, protocols, billing processes, and policies

42.13 consistent with medical assistance fee-for-service or the Department of Human Services

42.14 contract requirements for all personal care assistance services under section 256B.0659 and

42.15 community first services and supports under section 256B.85; and

42.16           (2) by January 30 of each year that follows a rate increase for any aspect of services

42.17 under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking

42.18 minority members of the legislative committees with jurisdiction over rates determined

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

40.28           Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and

40.29 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner

40.30 may issue separate contracts with requirements specific to services to medical assistance

40.31 recipients age 65 and older.

40.32           (b) A prepaid health plan providing covered health services for eligible persons pursuant

40.33 to chapters 256B and 256L is responsible for complying with the terms of its contract with

41.1 the commissioner. Requirements applicable to managed care programs under chapters 256B

41.2 and 256L established after the effective date of a contract with the commissioner take effect

41.3 when the contract is next issued or renewed.

41.4           (c) The commissioner shall withhold five percent of managed care plan payments under

41.5 this section and county-based purchasing plan payments under section 256B.692 for the

41.6 prepaid medical assistance program pending completion of performance targets. Each

41.7 performance target must be quantifiable, objective, measurable, and reasonably attainable,

41.8 except in the case of a performance target based on a federal or state law or rule. Criteria

41.9 for assessment of each performance target must be outlined in writing prior to the contract

41.10 effective date. Clinical or utilization performance targets and their related criteria must

41.11 consider evidence-based research and reasonable interventions when available or applicable

41.12 to the populations served, and must be developed with input from external clinical experts

41.13 and stakeholders, including managed care plans, county-based purchasing plans, and

41.14 providers. The managed care or county-based purchasing plan must demonstrate, to the

41.15 commissioner's satisfaction, that the data submitted regarding attainment of the performance

41.16 target is accurate. The commissioner shall periodically change the administrative measures

41.17 used as performance targets in order to improve plan performance across a broader range

41.18 of administrative services. The performance targets must include measurement of plan

41.19 efforts to contain spending on health care services and administrative activities. The

41.20 commissioner may adopt plan-specific performance targets that take into account factors

41.21 affecting only one plan, including characteristics of the plan's enrollee population. The

41.22 withheld funds must be returned no sooner than July of the following year if performance

41.23 targets in the contract are achieved. The commissioner may exclude special demonstration

41.24 projects under subdivision 23.

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

41.26           (1) use the assessment and authorization processes, forms, timelines, standards,

41.27 documentation, and data reporting requirements, protocols, billing processes, and policies

41.28 consistent with medical assistance fee-for-service or the Department of Human Services

41.29 contract requirements for all personal care assistance services under section 256B.0659 and

41.30 community first services and supports under section 256B.85; and

41.31           (2) by January 30 of each year that follows a rate increase for any aspect of services

41.32 under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking

41.33 minority members of the legislative committees with jurisdiction over rates determined

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

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

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

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

43.13 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall  
43.14 include as part of the performance targets described in paragraph (e) a reduction in the plan's  
43.15 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as  
43.16 determined by the commissioner. To earn the return of the withhold each year, the managed  
43.17 care plan or county-based purchasing plan must achieve a qualifying reduction of no less  
43.18 than five percent of the plan's hospital admission rate for medical assistance and  
43.19 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and  
43.20 28, compared to the previous calendar year until the final performance target is reached.  
43.21 When measuring performance, the commissioner must consider the difference in health risk  
43.22 in a managed care or county-based purchasing plan's membership in the baseline year  
43.23 compared to the measurement year, and work with the managed care or county-based  
43.24 purchasing plan to account for differences that they agree are significant.

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

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

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

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

42.27 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall  
42.28 include as part of the performance targets described in paragraph (e) a reduction in the plan's  
42.29 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as  
42.30 determined by the commissioner. To earn the return of the withhold each year, the managed  
42.31 care plan or county-based purchasing plan must achieve a qualifying reduction of no less  
42.32 than five percent of the plan's hospital admission rate for medical assistance and  
42.33 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and  
42.34 28, compared to the previous calendar year until the final performance target is reached.  
42.35 When measuring performance, the commissioner must consider the difference in health risk  
43.1 in a managed care or county-based purchasing plan's membership in the baseline year  
43.2 compared to the measurement year, and work with the managed care or county-based  
43.3 purchasing plan to account for differences that they agree are significant.



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

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

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

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

44.18 The withhold described in this paragraph must continue for each consecutive contract  
 44.19 period until the plan's subsequent hospitalization rate for medical assistance and  
 44.20 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and  
 44.21 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year  
 44.22 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall  
 44.23 accept payment withholds that must be returned to the hospitals if the performance target  
 44.24 is achieved.

44.25 ~~(h)~~ (e) Effective for services rendered on or after January 1, 2013, through December  
 44.26 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under  
 44.27 this section and county-based purchasing plan payments under section 256B.692 for the  
 44.28 prepaid medical assistance program. The withheld funds must be returned no sooner than  
 44.29 July 1 and no later than July 31 of the following year. The commissioner may exclude  
 44.30 special demonstration projects under subdivision 23.

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

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

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

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

43.32 The withhold described in this paragraph must continue for each consecutive contract  
 43.33 period until the plan's subsequent hospitalization rate for medical assistance and  
 43.34 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and  
 44.1 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year  
 44.2 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall  
 44.3 accept payment withholds that must be returned to the hospitals if the performance target  
 44.4 is achieved.

44.5 ~~(h)~~ (e) Effective for services rendered on or after January 1, 2013, through December  
 44.6 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under  
 44.7 this section and county-based purchasing plan payments under section 256B.692 for the  
 44.8 prepaid medical assistance program. The withheld funds must be returned no sooner than  
 44.9 July 1 and no later than July 31 of the following year. The commissioner may exclude  
 44.10 special demonstration projects under subdivision 23.

44.31 ~~(f)~~ (f) Effective for services rendered on or after January 1, 2014, the commissioner shall  
44.32 withhold three percent of managed care plan payments under this section and county-based  
44.33 purchasing plan payments under section 256B.692 for the prepaid medical assistance  
44.34 program. The withheld funds must be returned no sooner than July 1 and no later than July  
45.1 31 of the following year. The commissioner may exclude special demonstration projects  
45.2 under subdivision 23.

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

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

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

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

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

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

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

44.11 ~~(f)~~ (f) Effective for services rendered on or after January 1, 2014, the commissioner shall  
44.12 withhold three percent of managed care plan payments under this section and county-based  
44.13 purchasing plan payments under section 256B.692 for the prepaid medical assistance  
44.14 program. The withheld funds must be returned no sooner than July 1 and no later than July  
44.15 31 of the following year. The commissioner may exclude special demonstration projects  
44.16 under subdivision 23.

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

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

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

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

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

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

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

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

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

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

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

46.11 (2) for generic drugs or multisource brand name drugs, unless the multisource brand  
46.12 name drug is prescribed in accordance with Code of Federal Regulations, title 42, section  
46.13 447.512(c), a dispensing fee equal to one-half of the fee-for-service dispensing fee in section  
46.14 256B.0625, subdivision 13e, paragraph (a), plus the lesser of the National Average Drug  
46.15 Acquisition Cost for brand drugs; the National Average Drug Acquisition Cost for generic  
46.16 drugs; the Wholesale Acquisition Cost minus two percent; the maximum allowable cost;  
46.17 or the submitted charges;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

48.3           Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a)

48.4       The commissioner may contract with demonstration providers and current or former sponsors

48.5       of qualified Medicare-approved special needs plans, to provide medical assistance basic

48.6       health care services to persons with disabilities, including those with developmental

48.7       disabilities. Basic health care services include:

48.8           (1) those services covered by the medical assistance state plan except for ICF/DD services,

48.9       home and community-based waiver services, case management for persons with

48.10      developmental disabilities under section 256B.0625, subdivision 20a, and personal care and

48.11      certain home care services defined by the commissioner in consultation with the stakeholder

48.12      group established under paragraph (d); and

48.13           (2) basic health care services may also include risk for up to 100 days of nursing facility

48.14      services for persons who reside in a noninstitutional setting and home health services related

48.15      to rehabilitation as defined by the commissioner after consultation with the stakeholder

48.16      group.

48.17        The commissioner may exclude other medical assistance services from the basic health

48.18      care benefit set. Enrollees in these plans can access any excluded services on the same basis

48.19      as other medical assistance recipients who have not enrolled.

48.20           (b) The commissioner may contract with demonstration providers and current and former

48.21      sponsors of qualified Medicare special needs plans, to provide basic health care services

48.22      under medical assistance to persons who are dually eligible for both Medicare and Medicaid

48.23      and those Social Security beneficiaries eligible for Medicaid but in the waiting period for

48.24      Medicare. The commissioner shall consult with the stakeholder group under paragraph (d)

48.25      in developing program specifications for these services. Payment for Medicaid services

48.26      provided under this subdivision for the months of May and June will be made no earlier

48.27      than July 1 of the same calendar year.

48.28           (c) ~~Notwithstanding subdivision 4, beginning January 1, 2012,~~ The commissioner shall

48.29      enroll persons with disabilities in managed care under this section, unless the individual

48.30      chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out

48.31      procedures consistent with applicable enrollment procedures under this section.

48.32           (d) The commissioner shall establish a state-level stakeholder group to provide advice

48.33      on managed care programs for persons with disabilities, including both MnDHO and contracts

49.1      with special needs plans that provide basic health care services as described in paragraphs

49.2      (a) and (b). The stakeholder group shall provide advice on program expansions under this

49.3      subdivision and subdivision 23, including:

49.4           (1) implementation efforts;

49.5           (2) consumer protections; and

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

79.14           Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a)

79.15       The commissioner may contract with demonstration providers and current or former sponsors

79.16       of qualified Medicare-approved special needs plans, to provide medical assistance basic

79.17       health care services to persons with disabilities, including those with developmental

79.18       disabilities. Basic health care services include:

79.19           (1) those services covered by the medical assistance state plan except for ICF/DD services,

79.20       home and community-based waiver services, case management for persons with

79.21       developmental disabilities under section 256B.0625, subdivision 20a, and personal care and

79.22       certain home care services defined by the commissioner in consultation with the stakeholder

79.23       group established under paragraph (d); and

79.24           (2) basic health care services may also include risk for up to 100 days of nursing facility

79.25       services for persons who reside in a noninstitutional setting and home health services related

79.26       to rehabilitation as defined by the commissioner after consultation with the stakeholder

79.27       group.

79.28       The commissioner may exclude other medical assistance services from the basic health

79.29       care benefit set. Enrollees in these plans can access any excluded services on the same basis

79.30       as other medical assistance recipients who have not enrolled.

79.31           (b) The commissioner may contract with demonstration providers and current and former

79.32       sponsors of qualified Medicare special needs plans, to provide basic health care services

79.33       under medical assistance to persons who are dually eligible for both Medicare and Medicaid

80.1       and those Social Security beneficiaries eligible for Medicaid but in the waiting period for

80.2       Medicare. The commissioner shall consult with the stakeholder group under paragraph (d)

80.3       in developing program specifications for these services. Payment for Medicaid services

80.4       provided under this subdivision for the months of May and June will be made no earlier

80.5       than July 1 of the same calendar year.

80.6           (c) ~~Notwithstanding subdivision 4, beginning January 1, 2012,~~ The commissioner shall

80.7       enroll persons with disabilities in managed care under this section, unless the individual

80.8       chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out

80.9       procedures consistent with applicable enrollment procedures under this section.

80.10           (d) The commissioner shall establish a state-level stakeholder group to provide advice

80.11       on managed care programs for persons with disabilities, including both MnDHO and contracts

80.12       with special needs plans that provide basic health care services as described in paragraphs

80.13       (a) and (b). The stakeholder group shall provide advice on program expansions under this

80.14       subdivision and subdivision 23, including:

80.15           (1) implementation efforts;

80.16           (2) consumer protections; and

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

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

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

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

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

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

49.23 (b) The enrollee support system must:

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

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

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

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

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

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

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

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

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

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

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

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

81.5 (b) The enrollee support system must:

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

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

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

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

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

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

50.10 (d) The commissioner may designate enrollment brokers to assist enrollees on selecting  
50.11 a managed care organization and providing necessary enrollment information. For purposes  
50.12 of this subdivision, "enrollment broker" means an individual or entity that performs choice  
50.13 counseling or enrollment activities in accordance with Code of Federal Regulations, part  
50.14 42, section 438.810, or both.

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

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

50.17 Subdivision 1. **In general.** County boards or groups of county boards may elect to  
50.18 purchase or provide health care services on behalf of persons eligible for medical assistance  
50.19 who would otherwise be required to or may elect to participate in the prepaid medical  
50.20 assistance program according to section 256B.69, subject to the opt-out provision of section  
50.21 256B.69, subdivision 4, paragraph (a). Counties that elect to purchase or provide health  
50.22 care under this section must provide all services included in prepaid managed care programs  
50.23 according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this  
50.24 section is governed by section 256B.69, unless otherwise provided for under this section.

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

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

50.27 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

50.28 (a) For outpatient hospital facility fee payments for services rendered on or after October  
50.29 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,  
50.30 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for  
50.31 which there is a federal maximum allowable payment. Effective for services rendered on  
50.32 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and  
51.1 emergency room facility fees shall be increased by eight percent over the rates in effect on  
51.2 December 31, 1999, except for those services for which there is a federal maximum allowable  
51.3 payment. Services for which there is a federal maximum allowable payment shall be paid  
51.4 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total  
51.5 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare  
51.6 upper limit. If it is determined that a provision of this section conflicts with existing or  
51.7 future requirements of the United States government with respect to federal financial  
51.8 participation in medical assistance, the federal requirements prevail. The commissioner

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

81.23 (d) The commissioner may designate enrollment brokers to assist enrollees on selecting  
81.24 a managed care organization and providing necessary enrollment information. For purposes  
81.25 of this subdivision, "enrollment broker" means an individual or entity that performs choice  
81.26 counseling or enrollment activities in accordance with Code of Federal Regulations, part  
81.27 42, section 438.810, or both.

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

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

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

81.30 Subdivision 1. **In general.** County boards or groups of county boards may elect to  
81.31 purchase or provide health care services on behalf of persons eligible for medical assistance  
81.32 who would otherwise be required to or may elect to participate in the prepaid medical  
82.1 assistance program according to section 256B.69, subject to the opt-out provision of section  
82.2 256B.69, subdivision 4, paragraph (a). Counties that elect to purchase or provide health  
82.3 care under this section must provide all services included in prepaid managed care programs  
82.4 according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this  
82.5 section is governed by section 256B.69, unless otherwise provided for under this section.

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

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

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

82.8 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

82.9 (a) For outpatient hospital facility fee payments for services rendered on or after October  
82.10 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,  
82.11 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for  
82.12 which there is a federal maximum allowable payment. Effective for services rendered on  
82.13 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and  
82.14 emergency room facility fees shall be increased by eight percent over the rates in effect on  
82.15 December 31, 1999, except for those services for which there is a federal maximum allowable  
82.16 payment. Services for which there is a federal maximum allowable payment shall be paid  
82.17 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total  
82.18 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare  
82.19 upper limit. If it is determined that a provision of this section conflicts with existing or  
82.20 future requirements of the United States government with respect to federal financial  
82.21 participation in medical assistance, the federal requirements prevail. The commissioner

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

51.11 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory  
51.12 surgery hospital facility fee services for critical access hospitals designated under section  
51.13 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the  
51.14 cost-finding methods and allowable costs of the Medicare program. Effective for services  
51.15 provided on or after July 1, 2015, rates established for critical access hospitals under this  
51.16 paragraph for the applicable payment year shall be the final payment and shall not be settled  
51.17 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal  
51.18 year ending in 2017, the rate for outpatient hospital services shall be computed using  
51.19 information from each hospital's Medicare cost report as filed with Medicare for the year  
51.20 that is two years before the year that the rate is being computed. Rates shall be computed  
51.21 using information from Worksheet C series until the department finalizes the medical  
51.22 assistance cost reporting process for critical access hospitals. After the cost reporting process  
51.23 is finalized, rates shall be computed using information from Title XIX Worksheet D series.  
51.24 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs  
51.25 related to rural health clinics and federally qualified health clinics, divided by ancillary  
51.26 charges plus outpatient charges, excluding charges related to rural health clinics and federally  
51.27 qualified health clinics.

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

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

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

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

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

82.24 (b)(1) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory  
82.25 surgery hospital facility fee services for critical access hospitals designated under section  
82.26 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the  
82.27 cost-finding methods and allowable costs of the Medicare program. Effective for services  
82.28 provided on or after July 1, 2015, rates established for critical access hospitals under this  
82.29 paragraph for the applicable payment year shall be the final payment and shall not be settled  
82.30 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal  
82.31 year ending in 2017, the rate for outpatient hospital services shall be computed using  
82.32 information from each hospital's Medicare cost report as filed with Medicare for the year  
82.33 that is two years before the year that the rate is being computed. Rates shall be computed  
82.34 using information from Worksheet C series until the department finalizes the medical  
83.1 assistance cost reporting process for critical access hospitals. After the cost reporting process  
83.2 is finalized, rates shall be computed using information from Title XIX Worksheet D series.  
83.3 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs  
83.4 related to rural health clinics and federally qualified health clinics, divided by ancillary  
83.5 charges plus outpatient charges, excluding charges related to rural health clinics and federally  
83.6 qualified health clinics.

83.7 (2) The rate described in clause (1) must be increased for hospitals providing high levels  
83.8 of 340B drugs. The rate adjustment must be based on four percent of each hospital's share  
83.9 of the total reimbursement for 340B drugs to all critical access hospitals, but must not exceed  
83.10 \$3,000,000.

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

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

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



52.13 ~~(f)~~ (g) In addition to the reductions in paragraphs (d) and (e), the total payment for  
52.14 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient  
52.15 hospital facility services before third-party liability and spenddown, is reduced three percent  
52.16 from the current statutory rates. Mental health services and facilities defined under section  
52.17 256.969, subdivision 16, are excluded from this paragraph.

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

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

52.23 **256B.758 REIMBURSEMENT FOR DOULA SERVICES.**

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

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

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

53.1 Sec. 35. Minnesota Statutes 2022, section 256B.76, as amended by Laws 2023, chapter  
53.2 25, section 145, is amended to read:

53.3 **256B.76 PHYSICIAN, PROFESSIONAL SERVICES, AND DENTAL**  
53.4 **REIMBURSEMENT.**

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

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

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

83.27 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for  
83.28 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient  
83.29 hospital facility services before third-party liability and spenddown, is reduced three percent  
83.30 from the current statutory rates. Mental health services and facilities defined under section  
83.31 256.969, subdivision 16, are excluded from this paragraph.

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

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

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

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

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

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

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

53.24 (c) Effective for services rendered on or after July 1, 2009, payment rates for physician  
53.25 and professional services shall be reduced by five percent, except that for the period July  
53.26 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical  
53.27 assistance and general assistance medical care programs, over the rates in effect on June  
53.28 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other  
53.29 outpatient visits, preventive medicine visits and family planning visits billed by physicians,  
53.30 advanced practice **registered** nurses, or physician assistants in a family planning agency or  
53.31 in one of the following primary care practices: general practice, general internal medicine,  
53.32 general pediatrics, general geriatrics, and family medicine. This reduction and the reductions  
53.33 in paragraph (d) do not apply to federally qualified health centers, rural health centers, and  
53.34 Indian health services. Effective October 1, 2009, payments made to managed care plans  
54.1 and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall  
54.2 reflect the payment reduction described in this paragraph.

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

54.12 (e) Effective for services rendered on or after September 1, 2011, through June 30, 2013,  
54.13 payment rates for physician and professional services shall be reduced three percent from  
54.14 the rates in effect on August 31, 2011. This reduction does not apply to physical therapy  
54.15 services, occupational therapy services, and speech pathology and related services.

54.16 (f) Effective for services rendered on or after September 1, 2014, payment rates for  
54.17 physician and professional services, including physical therapy, occupational therapy, speech  
54.18 pathology, and mental health services shall be increased by five percent from the rates in  
54.19 effect on August 31, 2014. In calculating this rate increase, the commissioner shall not  
54.20 include in the base rate for August 31, 2014, the rate increase provided under section  
54.21 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,

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

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

45.23 (c) Effective for services rendered on or after July 1, 2009, payment rates for physician  
45.24 and professional services shall be reduced by five percent, except that for the period July  
45.25 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical  
45.26 assistance and general assistance medical care programs, over the rates in effect on June  
45.27 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other  
45.28 outpatient visits, preventive medicine visits and family planning visits billed by physicians,  
45.29 advanced practice nurses, or physician assistants in a family planning agency or in one of  
45.30 the following primary care practices: general practice, general internal medicine, general  
45.31 pediatrics, general geriatrics, and family medicine. This reduction and the reductions in  
45.32 paragraph (d) do not apply to federally qualified health centers, rural health centers, and  
45.33 Indian health services. Effective October 1, 2009, payments made to managed care plans  
46.1 and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall  
46.2 reflect the payment reduction described in this paragraph.

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

46.12 (e) Effective for services rendered on or after September 1, 2011, through June 30, 2013,  
46.13 payment rates for physician and professional services shall be reduced three percent from  
46.14 the rates in effect on August 31, 2011. This reduction does not apply to physical therapy  
46.15 services, occupational therapy services, and speech pathology and related services.

46.16 (f) Effective for services rendered on or after September 1, 2014, payment rates for  
46.17 physician and professional services, including physical therapy, occupational therapy, speech  
46.18 pathology, and mental health services shall be increased by five percent from the rates in  
46.19 effect on August 31, 2014. In calculating this rate increase, the commissioner shall not  
46.20 include in the base rate for August 31, 2014, the rate increase provided under section  
46.21 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,

54.22 rural health centers, and Indian health services. Payments made to managed care plans and  
54.23 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

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

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

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

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

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

55.8 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile  
55.9 of 1989, less the percent in aggregate necessary to equal the above increases.

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

55.13 (c) Effective for services rendered ~~on or after~~ from January 1, 2000, to December 31,  
55.14 2023, payment rates for dental services shall be increased by three percent over the rates in  
55.15 effect on December 31, 1999.

55.16 (d) Effective for services provided ~~on or after~~ from January 1, 2002, to December 31,  
55.17 2023, payment for diagnostic examinations and dental x-rays provided to children under  
55.18 age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999  
55.19 charges.

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

46.22 rural health centers, and Indian health services. Payments made to managed care plans and  
46.23 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

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

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

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

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

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

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

47.10 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile  
47.11 of 1989, less the percent in aggregate necessary to equal the above increases.

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

47.15 (c) Effective for services rendered ~~on or after~~ from January 1, 2000, to December 31,  
47.16 2023, payment rates for dental services shall be increased by three percent over the rates in  
47.17 effect on December 31, 1999.

47.18 (d) Effective for services provided ~~on or after~~ from January 1, 2002, to December 31,  
47.19 2023, payment for diagnostic examinations and dental x-rays provided to children under  
47.20 age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999  
47.21 charges.

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

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

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

55.32 (h) Effective for services rendered on or after January 1, 2014, through December 31,  
55.33 2021, payment rates for dental services shall be increased by five percent from the rates in  
56.1 effect on December 31, 2013. This increase does not apply to state-operated dental clinics  
56.2 in paragraph (f), federally qualified health centers, rural health centers, and Indian health  
56.3 services. Effective January 1, 2014, payments made to managed care plans and county-based  
56.4 purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment  
56.5 increase described in this paragraph.

56.6 (i) Effective for services provided on or after January 1, 2017, through December 31,  
56.7 2021, the commissioner shall increase payment rates by 9.65 percent for dental services  
56.8 provided outside of the seven-county metropolitan area. This increase does not apply to  
56.9 state-operated dental clinics in paragraph (f), federally qualified health centers, rural health  
56.10 centers, or Indian health services. Effective January 1, 2017, payments to managed care  
56.11 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect  
56.12 the payment increase described in this paragraph.

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

56.19 ~~(k)~~ (h) Effective for services provided on or after January 1, 2022, the commissioner  
56.20 shall exclude from medical assistance and MinnesotaCare payments for dental services to  
56.21 public health and community health clinics the 20 percent increase authorized under Laws  
56.22 1989, chapter 327, section 5, subdivision 2, paragraph (b).

56.23 ~~(h)~~ (i) Effective for services provided ~~on or after~~ from January 1, 2022, to December 31,  
56.24 2023, the commissioner shall increase payment rates by 98 percent for all dental services.  
56.25 This rate increase does not apply to state-operated dental clinics, federally qualified health  
56.26 centers, rural health centers, or Indian health services.

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

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

48.3 (h) Effective for services rendered on or after January 1, 2014, through December 31,  
48.4 2021, payment rates for dental services shall be increased by five percent from the rates in  
48.5 effect on December 31, 2013. This increase does not apply to state-operated dental clinics  
48.6 in paragraph (f), federally qualified health centers, rural health centers, and Indian health  
48.7 services. Effective January 1, 2014, payments made to managed care plans and county-based  
48.8 purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment  
48.9 increase described in this paragraph.

48.10 (i) Effective for services provided on or after January 1, 2017, through December 31,  
48.11 2021, the commissioner shall increase payment rates by 9.65 percent for dental services  
48.12 provided outside of the seven-county metropolitan area. This increase does not apply to  
48.13 state-operated dental clinics in paragraph (f), federally qualified health centers, rural health  
48.14 centers, or Indian health services. Effective January 1, 2017, payments to managed care  
48.15 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect  
48.16 the payment increase described in this paragraph.

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

48.23 ~~(k)~~ (h) Effective for services provided on or after January 1, 2022, the commissioner  
48.24 shall exclude from medical assistance and MinnesotaCare payments for dental services to  
48.25 public health and community health clinics the 20 percent increase authorized under Laws  
48.26 1989, chapter 327, section 5, subdivision 2, paragraph (b).

48.27 ~~(h)~~ (i) Effective for services provided ~~on or after~~ from January 1, 2022, to December 31,  
48.28 2023, the commissioner shall increase payment rates by 98 percent for all dental services.  
48.29 This rate increase does not apply to state-operated dental clinics, federally qualified health  
48.30 centers, rural health centers, or Indian health services.

56.27 ~~(m)~~ (j) Managed care plans and county-based purchasing plans shall reimburse providers  
56.28 at a level that is at least equal to the rate paid under fee-for-service for dental services. If,  
56.29 for any coverage year, federal approval is not received for this paragraph, the commissioner  
56.30 must adjust the capitation rates paid to managed care plans and county-based purchasing  
56.31 plans for that contract year to reflect the removal of this provision. Contracts between  
56.32 managed care plans and county-based purchasing plans and providers to whom this paragraph  
56.33 applies must allow recovery of payments from those providers if capitation rates are adjusted  
56.34 in accordance with this paragraph. Payment recoveries must not exceed an amount equal  
57.1 to any increase in rates that results from this provision. If, for any coverage year, federal  
57.2 approval is not received for this paragraph, the commissioner shall not implement this  
57.3 paragraph for subsequent coverage years.

57.4 (k) Effective for services provided on or after January 1, 2024, payment for dental  
57.5 services must be the lower of submitted charges or the percentile of 2018-submitted charges  
57.6 from claims paid by the commissioner so that the total aggregate expenditures does not  
57.7 exceed the total spend as outlined in the applicable paragraphs (a) to (k). This paragraph  
57.8 does not apply to federally qualified health centers, rural health centers, state-operated dental  
57.9 clinics, or Indian health centers.

57.10 (l) Beginning January 1, 2027, and every three years thereafter, the commissioner shall  
57.11 rebase payment rates for dental services to a percentile of submitted charges for the applicable  
57.12 base year using charge data from claims paid by the commissioner so that the total aggregate  
57.13 expenditures does not exceed the total spend as outlined in paragraph (k) plus the change  
57.14 in the Medicare Economic Index (MEI). In 2027, the change in the MEI must be measured  
57.15 from midyear of 2024 and 2026. For each subsequent rebasing, the change in the MEI must  
57.16 be measured between the years that are one year after the rebasing years. The base year  
57.17 used for each rebasing must be the calendar year that is two years prior to the effective date  
57.18 of the rebasing. This paragraph does not apply to federally qualified health centers, rural  
57.19 health centers, state-operated dental clinics, or Indian health centers.

57.20 Subd. 3. **Dental services grants.** (a) The commissioner shall award grants to community  
57.21 clinics or other nonprofit community organizations, political subdivisions, professional  
57.22 associations, or other organizations that demonstrate the ability to provide dental services  
57.23 effectively to public program recipients. Grants may be used to fund the costs related to  
57.24 coordinating access for recipients, developing and implementing patient care criteria,  
57.25 upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new  
57.26 providers, or other development costs that will improve access to dental care in a region.  
57.27 In awarding grants, the commissioner shall give priority to applicants that plan to serve  
57.28 areas of the state in which the number of dental providers is not currently sufficient to meet  
57.29 the needs of recipients of public programs or uninsured individuals. The commissioner shall  
57.30 consider the following in awarding the grants:

48.31 ~~(m)~~ (j) Managed care plans and county-based purchasing plans shall reimburse providers  
48.32 at a level that is at least equal to the rate paid under fee-for-service for dental services. If,  
48.33 for any coverage year, federal approval is not received for this paragraph, the commissioner  
48.34 must adjust the capitation rates paid to managed care plans and county-based purchasing  
49.1 plans for that contract year to reflect the removal of this provision. Contracts between  
49.2 managed care plans and county-based purchasing plans and providers to whom this paragraph  
49.3 applies must allow recovery of payments from those providers if capitation rates are adjusted  
49.4 in accordance with this paragraph. Payment recoveries must not exceed an amount equal  
49.5 to any increase in rates that results from this provision. If, for any coverage year, federal  
49.6 approval is not received for this paragraph, the commissioner shall not implement this  
49.7 paragraph for subsequent coverage years.

49.8 (k) Effective for services provided on or after January 1, 2024, payment for dental  
49.9 services must be the lower of submitted charges or the percentile of 2018-submitted charges  
49.10 from claims paid by the commissioner so that the total aggregate expenditures does not  
49.11 exceed the total spend as outlined in the applicable paragraphs (a) to (k). This paragraph  
49.12 does not apply to federally qualified health centers, rural health centers, state-operated dental  
49.13 clinics, or Indian health centers.

49.14 (l) Beginning January 1, 2028, and every three years thereafter, the commissioner shall  
49.15 rebase payment rates for dental services to a percentile of submitted charges for the applicable  
49.16 base year using charge data from claims paid by the commissioner so that the total aggregate  
49.17 expenditures does not exceed the total spend as outlined in paragraph (k) plus the change  
49.18 in the Medicare Economic Index (MEI). In 2028, the change in the MEI must be measured  
49.19 from midyear of 2025 and 2027. For each subsequent rebasing, the change in the MEI must  
49.20 be measured between the years that are one year after the rebasing years. The base year  
49.21 used for each rebasing must be the calendar year that is two years prior to the effective date  
49.22 of the rebasing. This paragraph does not apply to federally qualified health centers, rural  
49.23 health centers, state-operated dental clinics, or Indian health centers.

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

57.31 (1) potential to successfully increase access to an underserved population;

57.32 (2) the ability to raise matching funds;

57.33 (3) the long-term viability of the project to improve access beyond the period of initial

57.34 funding;

58.1 (4) the efficiency in the use of the funding; and

58.2 (5) the experience of the proposers in providing services to the target population.

58.3 (b) The commissioner shall monitor the grants and may terminate a grant if the grantee

58.4 does not increase dental access for public program recipients. The commissioner shall

58.5 consider grants for the following:

58.6 (1) implementation of new programs or continued expansion of current access programs

58.7 that have demonstrated success in providing dental services in underserved areas;

58.8 (2) a pilot program for utilizing hygienists outside of a traditional dental office to provide

58.9 dental hygiene services; and

58.10 (3) a program that organizes a network of volunteer dentists, establishes a system to

58.11 refer eligible individuals to volunteer dentists, and through that network provides donated

58.12 dental care services to public program recipients or uninsured individuals.

58.13 Subd. 4. **Critical access dental providers.** ~~(a) The commissioner shall increase~~

58.14 ~~reimbursements to dentists and dental clinics deemed by the commissioner to be critical~~

58.15 ~~access dental providers. For dental services rendered on or after July 1, 2016, through~~

58.16 ~~December 31, 2021, the commissioner shall increase reimbursement by 37.5 percent above~~

58.17 ~~the reimbursement rate that would otherwise be paid to the critical access dental provider,~~

58.18 ~~except as specified under paragraph (b). The commissioner shall pay the managed care~~

58.19 ~~plans and county-based purchasing plans in amounts sufficient to reflect increased~~

58.20 ~~reimbursements to critical access dental providers as approved by the commissioner.~~

58.21 ~~(b) For dental services rendered on or after July 1, 2016, through December 31, 2021,~~

58.22 ~~by a dental clinic or dental group that meets the critical access dental provider designation~~

58.23 ~~under paragraph (f), clause (4), and is owned and operated by a health maintenance~~

58.24 ~~organization licensed under chapter 62D, the commissioner shall increase reimbursement~~

58.25 ~~by 35 percent above the reimbursement rate that would otherwise be paid to the critical~~

58.26 ~~access provider.~~

58.27 ~~(c)~~ (a) The commissioner shall increase reimbursement to dentists and dental clinics

58.28 deemed by the commissioner to be critical access dental providers. For dental services

58.29 provided on or after January 1, 2022, by a dental provider deemed to be a critical access

58.30 dental provider under paragraph ~~(f)~~ (d), the commissioner shall increase reimbursement by

58.31 20 percent above the reimbursement rate that would otherwise be paid to the critical access

58.32 dental provider. This paragraph does not apply to federally qualified health centers, rural

58.33 health centers, state-operated dental clinics, or Indian health centers.

59.1 ~~(b)~~ (b) Managed care plans and county-based purchasing plans shall increase  
59.2 reimbursement to critical access dental providers by at least the amount specified in paragraph  
59.3 ~~(c)~~ (c). If, for any coverage year, federal approval is not received for this paragraph, the  
59.4 commissioner must adjust the capitation rates paid to managed care plans and county-based  
59.5 purchasing plans for that contract year to reflect the removal of this provision. Contracts  
59.6 between managed care plans and county-based purchasing plans and providers to whom  
59.7 this paragraph applies must allow recovery of payments from those providers if capitation  
59.8 rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed  
59.9 an amount equal to any increase in rates that results from this provision. If, for any coverage  
59.10 year, federal approval is not received for this paragraph, the commissioner shall not  
59.11 implement this paragraph for subsequent coverage years.

59.12 ~~(c)~~ (c) Critical access dental payments made under this subdivision for dental services  
59.13 provided by a critical access dental provider to an enrollee of a managed care plan or  
59.14 county-based purchasing plan must not reflect any capitated payments or cost-based payments  
59.15 from the managed care plan or county-based purchasing plan. The managed care plan or  
59.16 county-based purchasing plan must base the additional critical access dental payment on  
59.17 the amount that would have been paid for that service had the dental provider been paid  
59.18 according to the managed care plan or county-based purchasing plan's fee schedule that  
59.19 applies to dental providers that are not paid under a capitated payment or cost-based payment.

59.20 ~~(d)~~ (d) The commissioner shall designate the following dentists and dental clinics as  
59.21 critical access dental providers:

59.22 (1) nonprofit community clinics that:

59.23 (i) have nonprofit status in accordance with chapter 317A;

59.24 (ii) have tax exempt status in accordance with the Internal Revenue Code, section  
59.25 501(c)(3);

59.26 (iii) are established to provide oral health services to patients who are low income,  
59.27 uninsured, have special needs, and are underserved;

59.28 (iv) have professional staff familiar with the cultural background of the clinic's patients;

59.29 (v) charge for services on a sliding fee scale designed to provide assistance to low-income  
59.30 patients based on current poverty income guidelines and family size;

59.31 (vi) do not restrict access or services because of a patient's financial limitations or public  
59.32 assistance status; and

59.33 (vii) have free care available as needed;

60.1 (2) federally qualified health centers, rural health clinics, and public health clinics;

60.2 (3) hospital-based dental clinics owned and operated by a city, county, or former state  
60.3 hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);



60.4 (4) a dental clinic or dental group owned and operated by a nonprofit corporation in  
60.5 accordance with chapter 317A with more than 10,000 patient encounters per year with  
60.6 patients who are uninsured or covered by medical assistance or MinnesotaCare;

60.7 (5) a dental clinic owned and operated by the University of Minnesota or the Minnesota  
60.8 State Colleges and Universities system; and

60.9 (6) private practicing dentists if:

60.10 (i) the dentist's office is located within the seven-county metropolitan area and more  
60.11 than 50 percent of the dentist's patient encounters per year are with patients who are uninsured  
60.12 or covered by medical assistance or MinnesotaCare; or

60.13 (ii) the dentist's office is located outside the seven-county metropolitan area and more  
60.14 than 25 percent of the dentist's patient encounters per year are with patients who are uninsured  
60.15 or covered by medical assistance or MinnesotaCare.

60.16 Subd. 5. **Outpatient rehabilitation facility.** An entity that operates both a Medicare  
60.17 certified comprehensive outpatient rehabilitation facility and a facility which was certified  
60.18 prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to  
60.19 9570.3400, and for whom at least 33 percent of the clients receiving rehabilitation services  
60.20 in the most recent calendar year are medical assistance recipients, shall be reimbursed by  
60.21 the commissioner for rehabilitation services at rates that are 38 percent greater than the  
60.22 maximum reimbursement rate allowed under subdivision 1, paragraph (a), clause (2), when  
60.23 those services are (1) provided within the comprehensive outpatient rehabilitation facility  
60.24 and (2) provided to residents of nursing facilities owned by the entity.

60.25 Subd. 6. **Medicare relative value units.** Effective for services rendered on or after  
60.26 January 1, 2007, the commissioner shall make payments for physician and professional  
60.27 services based on the Medicare relative value units (RVU's). This change shall be budget  
60.28 neutral and the cost of implementing RVU's will be incorporated in the established conversion  
60.29 factor.

60.30 Subd. 7. **Payment for certain primary care services and immunization**  
60.31 **administration.** Payment for certain primary care services and immunization administration  
60.32 services rendered on or after January 1, 2013, through December 31, 2014, shall be made  
60.33 in accordance with section 1902(a)(13) of the Social Security Act.

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

61.4 Sec. 36. Minnesota Statutes 2022, section 256B.761, is amended to read:

61.5 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

61.6 (a) Effective for services rendered on or after July 1, 2001, payment for medication  
61.7 management provided to psychiatric patients, outpatient mental health services, day treatment



61.8 services, home-based mental health services, and family community support services shall  
61.9 be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of  
61.10 1999 charges.

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

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

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

61.29 (e) Effective for services rendered on or after January 1, 2024, payment rates for  
61.30 behavioral health services included in the rate analysis required by Laws 2021, First Special  
61.31 Session chapter 7, article 17, section 18, must be increased by eight percent from the rates  
61.32 in effect on December 31, 2023. Effective for services rendered on or after January 1, 2025,  
61.33 payment rates for behavioral health services included in the rate analysis required by Laws  
62.1 2021, First Special Session chapter 7, article 17, section 18, must be annually adjusted  
62.2 according to the Consumer Price Index for medical care services. For payments made in  
62.3 accordance with this paragraph, if and to the extent that the commissioner identifies that  
62.4 the state has received federal financial participation for behavioral health services in excess  
62.5 of the amount allowed under United States Code, title 42, section 447.321, the state shall  
62.6 repay the excess amount to the Centers for Medicare and Medicaid Services with state  
62.7 money and maintain the full payment rate under this paragraph. This paragraph does not  
62.8 apply to federally qualified health centers, rural health centers, Indian health services,  
62.9 certified community behavioral health clinics, cost-based rates, and rates that are negotiated  
62.10 with the county. This paragraph expires upon legislative implementation of the new rate  
62.11 methodology resulting from the rate analysis required by Laws 2021, First Special Session  
62.12 chapter 7, article 17, section 18.

62.13 (f) Effective January 1, 2024, the commissioner shall increase capitation payments made  
62.14 to managed care plans and county-based purchasing plans to reflect the behavioral health  
62.15 service rate increase provided in paragraph (e). Managed care and county-based purchasing

62.16 plans must use the capitation rate increase provided under this paragraph to increase payment  
62.17 rates to behavioral health services providers. The commissioner must monitor the effect of  
62.18 this rate increase on enrollee access to behavioral health services. If for any contract year  
62.19 federal approval is not received for this paragraph, the commissioner must adjust the  
62.20 capitation rates paid to managed care plans and county-based purchasing plans for that  
62.21 contract year to reflect the removal of this provision. Contracts between managed care plans  
62.22 and county-based purchasing plans and providers to whom this paragraph applies must  
62.23 allow recovery of payments from those providers if capitation rates are adjusted in accordance  
62.24 with this paragraph. Payment recoveries must not exceed the amount equal to any increase  
62.25 in rates that results from this provision.

62.26 Sec. 37. Minnesota Statutes 2022, section 256B.764, is amended to read:

62.27 **256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

62.28 (a) Effective for services rendered on or after July 1, 2007, payment rates for family  
62.29 planning services shall be increased by 25 percent over the rates in effect June 30, 2007,  
62.30 when these services are provided by a community clinic as defined in section 145.9268,  
62.31 subdivision 1.

62.32 (b) Effective for services rendered on or after July 1, 2013, payment rates for family  
62.33 planning services shall be increased by 20 percent over the rates in effect June 30, 2013,  
62.34 when these services are provided by a community clinic as defined in section 145.9268,  
63.1 subdivision 1. The commissioner shall adjust capitation rates to managed care and  
63.2 county-based purchasing plans to reflect this increase, and shall require plans to pass on the  
63.3 full amount of the rate increase to eligible community clinics, in the form of higher payment  
63.4 rates for family planning services.

63.5 (c) Effective for services provided on or after January 1, 2024, payment rates for family  
63.6 planning and abortion services must be increased by ten percent. This increase does not  
63.7 apply to federally qualified health centers, rural health centers, or Indian health services.

49.27 Sec. 29. Minnesota Statutes 2022, section 256B.764, is amended to read:

49.28 **256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

49.29 (a) Effective for services rendered on or after July 1, 2007, payment rates for family  
49.30 planning services shall be increased by 25 percent over the rates in effect June 30, 2007,  
49.31 when these services are provided by a community clinic as defined in section 145.9268,  
49.32 subdivision 1.

50.1 (b) Effective for services rendered on or after July 1, 2013, payment rates for family  
50.2 planning services shall be increased by 20 percent over the rates in effect June 30, 2013,  
50.3 when these services are provided by a community clinic as defined in section 145.9268,  
50.4 subdivision 1. The commissioner shall adjust capitation rates to managed care and  
50.5 county-based purchasing plans to reflect this increase, and shall require plans to pass on the  
50.6 full amount of the rate increase to eligible community clinics, in the form of higher payment  
50.7 rates for family planning services.

50.8 (c) Effective for services provided on or after January 1, 2024, payment rates for family  
50.9 planning and abortion services shall be increased by 20 percent. This increase does not  
50.10 apply to federally qualified health centers, rural health centers, or Indian health services.

50.11 Sec. 30. Minnesota Statutes 2022, section 256L.03, subdivision 1, is amended to read:

50.12 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health  
50.13 services reimbursed under chapter 256B, with the exception of special education services,  
50.14 home care nursing services, adult dental care services other than services covered under  
50.15 section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation  
50.16 services, personal care assistance and case management services, community first services  
50.17 and supports under section 256B.85, behavioral health home services under section  
50.18 256B.0757, housing stabilization services under section 256B.051, and nursing home or  
50.19 intermediate care facilities services.

50.20 (b) ~~No public funds shall be used for coverage of abortion under MinnesotaCare except~~  
50.21 ~~where the life of the female would be endangered or substantial and irreversible impairment~~

63.8       Sec. 38. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

63.9           Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to

63.10 children under the age of 21 ~~and~~; to American Indians as defined in Code of Federal

63.11 Regulations, title 42, section 600.5; or to pre-exposure prophylaxis (PrEP) and postexposure

63.12 prophylaxis (PEP) medications when used for the prevention or treatment of the human

63.13 immunodeficiency virus (HIV).

63.14           (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered

63.15 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.

63.16 The cost-sharing changes described in this paragraph do not apply to eligible recipients or

63.17 services exempt from cost-sharing under state law. The cost-sharing changes described in

63.18 this paragraph shall not be implemented prior to January 1, 2016.

63.19           (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements

63.20 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,

63.21 title 42, sections 600.510 and 600.520.

63.22           (d) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic

63.23 services or testing that a health care provider determines an enrollee requires after a

63.24 mammogram, as specified under section 62A.30, subdivision 5.

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

63.26 whichever is later. The commissioner of human services shall notify the revisor of statutes

63.27 when federal approval is obtained.

50.22 ~~of a major bodily function would result if the fetus were carried to term, or where the~~

50.23 ~~pregnancy is the result of rape or incest.~~

50.24           ~~(e)~~ (b) Covered health services shall be expanded as provided in this section.

50.25           ~~(d)~~ (c) For the purposes of covered health services under this section, "child" means an

50.26 individual younger than 19 years of age.

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

S2995-3, ARTICLE 1, SECTION 38, MATCHES THE NEXT THREE SUBSEQUENT SECTIONS.

50.28       Sec. 31. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

50.29           Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to

50.30 children under the age of 21 ~~and~~ to American Indians as defined in Code of Federal

50.31 Regulations, title 42, section 600.5.

51.1           (b) The commissioner ~~shall~~ must adjust co-payments, coinsurance, and deductibles for

51.2 covered services in a manner sufficient to maintain the actuarial value of the benefit to 94

51.3 percent. The cost-sharing changes described in this paragraph do not apply to eligible

51.4 recipients or services exempt from cost-sharing under state law. The cost-sharing changes

51.5 described in this paragraph shall not be implemented prior to January 1, 2016.

51.6           (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements

51.7 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,

51.8 title 42, sections 600.510 and 600.520.

51.9           (d) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to

51.10 tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

51.11           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.

532.4       Sec. 15. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

532.5           Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to

532.6 children under the age of 21 and to American Indians as defined in Code of Federal

532.7 Regulations, title 42, section 600.5.

64.1       Sec. 39. Laws 2021, First Special Session chapter 7, article 6, section 26, is amended to  
64.2 read:  
64.3       Sec. 26. **COMMISSIONER OF HUMAN SERVICES; EXTENSION OF COVID-19**  
64.4 **HUMAN SERVICES PROGRAM MODIFICATIONS.**

64.5       Notwithstanding Laws 2020, First Special Session chapter 7, section 1, subdivision 2,  
64.6 as amended by Laws 2020, Third Special Session chapter 1, section 3, when the peacetime  
64.7 emergency declared by the governor in response to the COVID-19 outbreak expires, is  
64.8 terminated, or is rescinded by the proper authority, the following modifications issued by  
64.9 the commissioner of human services pursuant to Executive Orders 20-11 and 20-12, and

532.8       (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered  
532.9 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.  
532.10 The cost-sharing changes described in this paragraph do not apply to eligible recipients or  
532.11 services exempt from cost-sharing under state law. The cost-sharing changes described in  
532.12 this paragraph shall not be implemented prior to January 1, 2016.

532.13       (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements  
532.14 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,  
532.15 title 42, sections 600.510 and 600.520.

532.16       (d) Cost-sharing for prescription drugs and related medical supplies to treat chronic  
532.17 disease must comply with the requirements of section 62Q.481.

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

532.19       Sec. 16. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

532.20       Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to  
532.21 children under the age of 21 and to American Indians as defined in Code of Federal  
532.22 Regulations, title 42, section 600.5.

532.23       (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered  
532.24 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.  
532.25 The cost-sharing changes described in this paragraph do not apply to eligible recipients or  
532.26 services exempt from cost-sharing under state law. The cost-sharing changes described in  
532.27 this paragraph shall not be implemented prior to January 1, 2016.

532.28       (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements  
532.29 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,  
532.30 title 42, sections 600.510 and 600.520.

533.1       (d) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic  
533.2 services or testing that a health care provider determines an enrollee requires after a  
533.3 mammogram, as specified under section 62A.30, subdivision 5.

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

51.12       Sec. 32. Laws 2021, First Special Session chapter 7, article 6, section 26, is amended to  
51.13 read:  
51.14       Sec. 26. **COMMISSIONER OF HUMAN SERVICES; EXTENSION OF COVID-19**  
51.15 **HUMAN SERVICES PROGRAM MODIFICATIONS.**

51.16       Notwithstanding Laws 2020, First Special Session chapter 7, section 1, subdivision 2,  
51.17 as amended by Laws 2020, Third Special Session chapter 1, section 3, when the peacetime  
51.18 emergency declared by the governor in response to the COVID-19 outbreak expires, is  
51.19 terminated, or is rescinded by the proper authority, the following modifications issued by  
51.20 the commissioner of human services pursuant to Executive Orders 20-11 and 20-12, and

64.10 including any amendments to the modification issued before the peacetime emergency  
64.11 expires, shall remain in effect until July 1, ~~2023~~ 2025:

64.12 (1) CV16: expanding access to telemedicine services for Children's Health Insurance  
64.13 Program, Medical Assistance, and MinnesotaCare enrollees; and

64.14 (2) CV21: allowing telemedicine alternative for school-linked mental health services  
64.15 and intermediate school district mental health services.

64.16 Sec. 40. **REPORT; MODIFY WITHHOLD PROVISIONS.**

64.17 By January 1, 2024, the commissioner of human services must submit a report to the  
64.18 chairs and ranking minority members of the legislative committees with jurisdiction over  
64.19 human services finance and policy evaluating the utility of the performance targets described  
64.20 in Minnesota Statutes 2022, section 256B.69, subdivision 5a, paragraphs (e) to (g). The  
64.21 report must include the applicable performance rates of managed care organizations and  
64.22 county-based purchasing plans in the past three years, projected impacts on performance  
64.23 rates for the next three years resulting from a repeal of Minnesota Statutes 2022, section  
64.24 256B.69, subdivision 5a, paragraphs (e) to (g), measures that the commissioner anticipates  
64.25 taking to continue monitoring and improving the applicable performance rates of managed  
64.26 care organizations and county-based purchasing plans upon a repeal of Minnesota Statutes  
64.27 2022, section 256B.69, subdivision 5a, paragraphs (e) to (g), proposals for additional  
64.28 performance targets that may improve quality of care for enrollees, and any additional  
64.29 legislative actions that may be required as the result of a repeal of Minnesota Statutes 2022,  
64.30 section 256B.69, subdivision 5a, paragraphs (e) to (g).

51.21 including any amendments to the modification issued before the peacetime emergency  
51.22 expires, shall remain in effect until July 1, ~~2023~~ 2025:

51.23 (1) CV16: expanding access to telemedicine services for Children's Health Insurance  
51.24 Program, Medical Assistance, and MinnesotaCare enrollees; and

51.25 (2) CV21: allowing telemedicine alternative for school-linked mental health services  
51.26 and intermediate school district mental health services.

51.27 Sec. 33. **REPEALER.**

51.28 Minnesota Rules, part 9505.0235, is repealed the day following final enactment.