Senate Language S2995-3

House Language UES2995-2

ARTICLE 5

MEDICAL EDUCATION AND RESEARCH COSTS

Section 1. Minnesota Statutes 2022, section 62J.692, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply:

(b) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body who reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health.

(c) "Commissioner" means the commissioner of health.

(d) "Clinical medical education program" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners (pharmacy students and residents), doctors of chiropractic, dentists (dental students and residents), advanced practice registered nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers.

(e) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility for a clinical medical education program in Minnesota and which is accountable to the accrediting body.

(f) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota.

(g) "Trainee" means a student or resident involved in a clinical medical education program.

(h) "Eligible trainee FTE's" means the number of trainees, as measured by full-time equivalent counts, that are at training sites located in Minnesota with currently active medical assistance enrollment status and a National Provider Identification (NPI) number where training occurs ~~in~~ as part of or under the scope of either an inpatient or ambulatory patient care setting and where the training is funded, in part, by patient care revenues. Training that occurs in nursing facility settings is not eligible for funding under this section.

Sec. 2. Minnesota Statutes 2022, section 62J.692, subdivision 3, is amended to read:

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, physician assistants, dental therapists and advanced dental therapists,

ARTICLE 4

MEDICAL EDUCATION AND RESEARCH COSTS

Section 1. Minnesota Statutes 2022, section 62J.692, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply:

(b) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body who reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health.

(c) "Commissioner" means the commissioner of health.

(d) "Clinical medical education program" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners (pharmacy students and residents), doctors of chiropractic, dentists (dental students and residents), advanced practice registered nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers.

(e) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility for a clinical medical education program in Minnesota and which is accountable to the accrediting body.

(f) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota.

(g) "Trainee" means a student or resident involved in a clinical medical education program.

(h) "Eligible trainee FTE's" means the number of trainees, as measured by full-time equivalent counts, that are at training sites located in Minnesota with currently active medical assistance enrollment status and a National Provider Identification (NPI) number where training occurs in either an inpatient or ambulatory patient care setting and where the training is funded, in part, by patient care revenues. Training that occurs in nursing facility settings is not eligible for funding under this section.

Sec. 2. Minnesota Statutes 2022, section 62J.692, subdivision 3, is amended to read:

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, physician assistants, dental therapists and advanced dental therapists,

Senate Language S2995-3

psychologists, clinical social workers, community paramedics, or community health workers is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; ~~and~~

(3) includes training hours in settings outside of the hospital or clinic site, as applicable, including but not limited to school, home, and community settings; and

~~(3)~~ (4) emphasizes primary care or specialties that are in undersupply in Minnesota.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program ~~and must be received by October 31 of each year for distribution in the following year~~ on a timeline determined by the commissioner. An application for funds must contain ~~the following information:~~ information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

~~(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;~~

~~(2) the name, title, and business address of those persons responsible for administering the funds;~~

~~(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number and national provider identification number of each training site used in the program; the federal tax identification number of each training site used in the program, where available; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and~~

~~(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.~~

~~(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After~~

House Language UES2995-2

psychologists, clinical social workers, community paramedics, or community health workers is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program ~~and must be received by October 31 of each year for distribution in the following year~~ on a timeline determined by the commissioner. An application for funds must contain ~~the following information:~~ information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

~~(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;~~

~~(2) the name, title, and business address of those persons responsible for administering the funds;~~

~~(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number and national provider identification number of each training site used in the program; the federal tax identification number of each training site used in the program, where available; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and~~

~~(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.~~

~~(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After~~

Senate Language S2995-3

~~that time, an application must include the information specified in clauses (1) to (3) when requested, at the discretion of the commissioner:~~

~~(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;~~

~~(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and~~

~~(3) other revenue received for the purposes of clinical training.~~

~~(c)~~ (d) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the ~~current~~ applicable funding cycle.

Sec. 3. Minnesota Statutes 2022, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute ~~the available medical education funds~~ revenue credited or money transferred to the medical education and research cost account under subdivision 8 and section 297F.10, subdivision 1, clause (2), to all qualifying applicants based on a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

Public program revenue for the distribution formula includes revenue from medical assistance and prepaid medical assistance. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. ~~For purposes of determining training-site level grants to be distributed under this paragraph, total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.~~

Training sites whose training site level grant is less than $5,000, based on the ~~formula~~ formulas described in this ~~paragraph~~ subdivision, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the ~~formula~~ formulas described in this ~~paragraph~~ subdivision.

(b) ~~For funds distributed in fiscal years 2014 and 2015, the distribution formula shall include a supplemental public program volume factor, which is determined by providing a supplemental payment to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The supplemental public program volume factor shall be equal to ten percent of each training~~

House Language UES2995-2

~~that time, an application must include the information specified in clauses (1) to (3) when requested, at the discretion of the commissioner:~~

~~(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;~~

~~(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and~~

~~(3) other revenue received for the purposes of clinical training.~~

~~(c)~~ (d) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the ~~current~~ applicable funding cycle.

Sec. 3. Minnesota Statutes 2022, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute ~~the available medical education funds~~ revenue credited or money transferred to the medical education and research costs account under subdivision 8 and section 297F.10, subdivision 1, clause (2), to all qualifying applicants based on a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

Public program revenue for the distribution formula includes revenue from medical assistance and prepaid medical assistance. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. ~~For purposes of determining training-site level grants to be distributed under this paragraph, total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.~~

Training sites whose training site level grant is less than $5,000, based on the ~~formula~~ formulas described in this ~~paragraph~~ subdivision, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the ~~formula~~ formulas described in this ~~paragraph~~ subdivision.

(b) ~~For funds distributed in fiscal years 2014 and 2015, the distribution formula shall include a supplemental public program volume factor, which is determined by providing a supplemental payment to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The supplemental public program volume factor shall be equal to ten percent of each training~~

~~site's grant for funds distributed in fiscal year 2014 and for funds distributed in fiscal year 2015. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment. For fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public program volume factor as described in paragraph (a).~~ Money appropriated through the state general fund, the health care access fund, and any additional fund for the purpose of funding medical education and research costs and that does not require federal approval must be awarded only to eligible training sites that do not qualify for a medical education and research cost rate factor under sections 256.969, subdivision 2b, paragraph (k), or 256B.75, paragraph (b). The commissioner shall distribute the available medical education money appropriated to eligible training sites that do not qualify for a medical education and research cost rate factor based on a distribution formula determined by the commissioner. The distribution formula under this paragraph must consider clinical training costs, public program revenues, and other factors identified by the commissioner that address the objective of supporting clinical training.

(c) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraphs (a) and (b) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include ~~the withholding of payments~~ disqualifying the training site under this section or the removal of students from the site.

(e) Use of funds is limited to expenses related to eligible clinical training ~~program~~ costs ~~for eligible programs~~. The commissioner shall develop a methodology for determining eligible costs.

(f) Any funds ~~not~~ that cannot be distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. ~~The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.~~

~~site's grant for funds distributed in fiscal year 2014 and for funds distributed in fiscal year 2015. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment. For fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public program volume factor as described in paragraph (a).~~ Money appropriated through the state general fund, the health care access fund, and any additional fund for the purpose of funding medical education and research costs and that does not require federal approval must be awarded only to eligible training sites that do not qualify for a medical education and research cost rate factor under sections 256.969, subdivision 2b, paragraph (k), or 256B.75, paragraph (b). The commissioner shall distribute the available medical education money appropriated to eligible training sites that do not qualify for a medical education and research cost rate factor based on a distribution formula determined by the commissioner. The distribution formula under this paragraph must consider clinical training costs, public program revenues, and other factors identified by the commissioner that address the objective of supporting clinical training.

(c) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under paragraphs (a) and (b) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include ~~the withholding of payments~~ disqualifying the training site under this section or the removal of students from the site.

(e) Use of funds is limited to expenses related to eligible clinical training ~~program~~ costs ~~for eligible programs~~. The commissioner shall develop a methodology for determining eligible costs.

(f) Any funds ~~not~~ that cannot be distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. ~~The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.~~

Senate Language S2995-3

When appropriate, the commissioner shall include the undistributed money in the subsequent distribution cycle using the applicable methodology described in this subdivision.

~~(g) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.~~

Sec. 4. Minnesota Statutes 2022, section 62J.692, subdivision 5, is amended to read:

Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must ~~sign and~~ submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible training site. ~~If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.~~

(b) The reports must provide verification of the distribution of the funds and must include:

~~(1) the total number of eligible trainee FTEs in each clinical medical education program;~~

~~(2) the name of each funded program and, for each program, the dollar amount distributed to each training site and a training site expenditure report;~~

~~(3)~~ (1) documentation of any discrepancies between the ~~initial~~ grant distribution notice included in the commissioner's approval letter and the actual distribution;

~~(4)~~ (2) a statement by the sponsoring institution stating that the completed grant verification report is valid and accurate; and

~~(5)~~ (3) other information the commissioner deems appropriate to evaluate the effectiveness of the use of funds for medical education.

~~(c) Each year, the commissioner shall provide an annual summary report to the legislature on the implementation of this section. This report is exempt from section 144.05, subdivision 7.~~

Sec. 5. Minnesota Statutes 2022, section 62J.692, subdivision 8, is amended to read:

Subd. 8. **Federal financial participation.** The commissioner of human services shall seek ~~to maximize~~ federal financial participation ~~in payments~~ for the dedicated revenue for medical education and research costs provided under section 297F.10, subdivision 1, clause (2).

~~The commissioner shall use physician clinic rates where possible to maximize federal financial participation. Any additional funds that become available must be distributed under subdivision 4, paragraph (a).~~

House Language UES2995-2

When appropriate, the commissioner shall include the undistributed money in the subsequent distribution cycle using the applicable methodology described in this subdivision.

~~(g) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.~~

Sec. 4. Minnesota Statutes 2022, section 62J.692, subdivision 5, is amended to read:

Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must ~~sign and~~ submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible training site. ~~If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.~~

(b) The reports must provide verification of the distribution of the funds and must include:

~~(1) the total number of eligible trainee FTEs in each clinical medical education program;~~

~~(2) the name of each funded program and, for each program, the dollar amount distributed to each training site and a training site expenditure report;~~

~~(3)~~ (1) documentation of any discrepancies between the ~~initial~~ grant distribution notice included in the commissioner's approval letter and the actual distribution;

~~(4)~~ (2) a statement by the sponsoring institution stating that the completed grant verification report is valid and accurate; and

~~(5)~~ (3) other information the commissioner deems appropriate to evaluate the effectiveness of the use of funds for medical education.

~~(c) Each year, the commissioner shall provide an annual summary report to the legislature on the implementation of this section. This report is exempt from section 144.05, subdivision 7.~~

Sec. 5. Minnesota Statutes 2022, section 62J.692, subdivision 8, is amended to read:

Subd. 8. **Federal financial participation.** The commissioner of human services shall seek ~~to maximize~~ federal financial participation ~~in payments~~ for the dedicated revenue for medical education and research costs provided under section 297F.10, subdivision 1, clause (2).

~~The commissioner shall use physician clinic rates where possible to maximize federal financial participation. Any additional funds that become available must be distributed under subdivision 4, paragraph (a).~~

Senate Language S2995-3

House Language UES2995-2

Sec. 6. Minnesota Statutes 2022, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents, mental health professionals, and alcohol and drug counselors agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of ~~pediatric~~ psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(3) for nurses who agree to practice in a Minnesota nursing home; in an intermediate care facility for persons with developmental disability; in a hospital if the hospital owns and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home; ~~a housing with services establishment~~ in an assisted living facility as defined in section ~~144D.01~~ 144G.08, subdivision ~~4~~ 7; or for a home care provider as defined in section 144A.43, subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(4) for other health care technicians agreeing to teach at least 12 credit hours, or 720 hours per year in their designated field in a postsecondary program at the undergraduate level or the equivalent at the graduate level. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses who agree to practice in designated rural areas; and

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

THIS SECTION ALSO APPEARS IN THE HHS ARTICLE 3 COMPARISON (S2995-3, ARTICLE 3, SECTION 2, AND UES2995-2, ARTICLE 3, SECTION 48)

Senate Language S2995-3

House Language UES2995-2

Sec. 7. Minnesota Statutes 2022, section 144.1501, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an individual must:

(1) be a medical or dental resident; be a licensed pharmacist; or be enrolled in a training or education program or obtaining required supervision hours to become a dentist, dental therapist, advanced dental therapist, mental health professional, alcohol and drug counselor, pharmacist, public health nurse, midlevel practitioner, registered nurse, or a licensed practical nurse. The commissioner may also consider applications submitted by graduates in eligible professions who are licensed and in practice; and

(2) submit an application to the commissioner of health.

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training, with the exception of a nurse, who must agree to serve a minimum two-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training.

Sec. 8. Minnesota Statutes 2022, section 144.1506, subdivision 4, is amended to read:

Subd. 4. **Consideration of expansion grant applications.** The commissioner shall review each application to determine whether or not the residency program application is complete and whether the proposed new residency program and any new residency slots are eligible for a grant. The commissioner shall award grants to support up to six family medicine, general internal medicine, or general pediatrics residents; ~~four~~ five psychiatry residents; two geriatrics residents; and two general surgery residents. If insufficient applications are received from any eligible specialty, funds may be redistributed to applications from other eligible specialties.

Sec. 9. **[144.1507] PEDIATRIC PRIMARY CARE MENTAL HEALTH TRAINING GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health shall award grants for the development of child mental health training programs that are located in outpatient primary care clinics. To be eligible for a grant, a training program must:

(1) focus on the training of pediatric primary care providers working with multidisciplinary mental health teams;

(2) provide training on conducting comprehensive clinical mental health assessments and potential pharmacological therapy;

THIS SECTION ALSO APPEARS IN THE HHS ARTICLE 3 COMPARISON (S2995-3, ARTICLE 3, SECTION 3 AND UES2995-2, ARTICLE 3, SECTION 49)

(3) provide psychiatric consultation to pediatric primary care providers during their outpatient pediatric primary care experiences;

(4) emphasize longitudinal care for patients with behavioral health needs; and

(5) develop partnerships with community resources.

Subd. 2. **Child mental health training grant program.** (a) Child mental health training grants may be awarded to eligible primary care training programs to plan and implement new programs or expand existing programs in child mental health training.

(b) Money may be spent to cover the costs of:

(1) planning related to implementing or expanding child mental health training in an outpatient primary care clinic setting;

(2) training site improvements, fees, equipment, and supplies required for implementation of the training programs; and

(3) supporting clinical training in the outpatient primary clinic sites.

Subd. 3. **Applications for child mental health training grants.** Eligible primary care training programs seeking a grant shall apply to the commissioner. Applications must include the location of the training; a description of the training program, including all costs associated with the training program; all sources of money for the training program; detailed uses of all money for the training program; the results expected; and a plan to maintain the training program after the grant period. The applicant must describe achievable objectives and a timetable for the training program.

Subd. 4. **Consideration of child mental health training grant applications.** The commissioner shall review each application to determine whether the application meets the stated goals of the grant and shall award grants to support up to four training program proposals.

Subd. 5. **Program oversight.** During the grant period, the commissioner may require and collect from grantees any information necessary to evaluate the training program.

Sec. 10. **[144.1511] MENTAL HEALTH CULTURAL COMMUNITY CONTINUING EDUCATION GRANT PROGRAM.**

The mental health cultural community continuing education grant program is established in the Department of Health to provide grants for the continuing education necessary for social workers, marriage and family therapists, psychologists, and professional clinical counselors to become supervisors for individuals pursuing licensure in mental health professions. The commissioner must consult with the relevant mental health licensing boards in creating the program. To be eligible for a grant under this section, a social worker, marriage and family therapist, psychologist, or professional clinical counselor must:

Senate Language S2995-3

(1) be a member of a community of color or an underrepresented community as defined in section 148E.010, subdivision 20; and

(2) work for a community mental health provider and agree to deliver at least 25 percent of their yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303.

Sec. 11. **[144.1913] CLINICAL DENTAL EDUCATION INNOVATION GRANTS.**

(a) The commissioner of health shall award clinical dental education innovation grants to teaching institutions and clinical training sites for projects that increase dental access for underserved populations and promote innovative clinical training of dental professionals. In awarding the grants, the commissioner shall consider the following:

(1) potential to successfully increase access to dental services for an underserved population;

(2) the long-term viability of the project to improve access to dental services beyond the period of initial funding;

(3) evidence of collaboration between the applicant and local communities;

(4) efficiency in the use of grant money; and

(5) the priority level of the project in relation to state education, access, and workforce goals.

(b) The commissioner shall periodically evaluate the priorities in awarding innovations grants under this section to ensure that the priorities meet the changing workforce needs of the state.

Sec. 12. **[144.88] MENTAL HEALTH AND SUBSTANCE USE DISORDER EDUCATION CENTER.**

Subdivision 1. **Establishment.** The Mental Health and Substance Use Disorder Education Center is established in the Department of Health. The purpose of the center is to increase the number of professionals, practitioners, and peers working in mental health and substance use disorder treatment; increase the diversity of professionals, practitioners, and peers working in mental health and substance use disorder treatment; and facilitate a culturally informed and responsive mental health and substance use disorder treatment workforce.

Subd. 2. **Activities.** The Mental Health and Substance Use Disorder Education Center must:

House Language UES2995-2

Sec. 6. **[144.1913] CLINICAL DENTAL EDUCATION INNOVATION GRANTS.**

(a) The commissioner shall award clinical dental education innovation grants to teaching institutions and clinical training sites for projects that increase dental access for underserved populations and promote innovative clinical training of dental professionals. In awarding the grants, the commissioner shall consider the following:

(1) the potential to successfully increase access to dental services for an underserved population;

(2) the long-term viability of the project to improve access to dental services beyond the period of initial funding;

(3) the evidence of collaboration between the applicant and local communities;

(4) the efficiency in the use of grant funding; and

(5) the priority level of the project in relation to state education, access, and workforce goals.

(b) The commissioner shall periodically evaluate the priorities in awarding innovations grants under this section to ensure that the priorities meet the changing workforce needs of the state.

(1) analyze the geographic and demographic availability of licensed professionals in the field, identify gaps, and prioritize the need for additional licensed professionals by type, location, and demographics;

(2) create a program that exposes high school and college students to careers in the mental health and substance use disorder treatment field;

(3) create a website for individuals considering becoming a mental health provider that clearly labels the steps necessary to achieve licensure and certification in the various mental health fields and lists resources and links for more information;

(4) create a job board for organizations seeking employees to provide mental health and substance use disorder treatment, services, and supports;

(5) track the number of students at the college and graduate level who are graduating from programs that could facilitate a career as a mental health or substance use disorder treatment practitioner or professional and work with the colleges and universities to support the students in obtaining licensure;

(6) identify barriers to licensure and make recommendations to address the barriers;

(7) establish learning collaborative partnerships with mental health and substance use disorder treatment providers, schools, criminal justice agencies, and others;

(8) promote and expand loan forgiveness programs, funding for professionals to become supervisors, funding to pay for supervision, and funding for pathways to licensure;

(9) identify barriers to using loan forgiveness programs and develop recommendations to address the barriers;

(10) work to expand Medicaid graduate medical education to other mental health professionals;

(11) identify current sites for internships and practicums and assess the need for additional sites;

(12) develop training for other health care professionals to increase their knowledge about mental health and substance use disorder treatment, including but not limited to community health workers, pediatricians, primary care physicians, physician assistants, and nurses; and

(13) support training for integrated mental health and primary care in rural areas.

Subd. 3. **Reports.** Beginning January 1, 2024, the commissioner of health shall submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health finance and policy summarizing the center's activities and progress in addressing the mental health and substance use disorder treatment workforce shortage.

Senate Language S2995-3

Sec. 13. **[145.9272] FEDERALLY QUALIFIED HEALTH CENTERS APPRENTICESHIP PROGRAM.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

(b) "Federally qualified health center" has the meaning given in section 145.9269, subdivision 1.

(c) "Nonprofit organization of community health centers" means a nonprofit organization the membership of which consists of federally qualified health centers operating service delivery sites in Minnesota and that provides services to federally qualified health centers in Minnesota to promote the delivery of affordable, quality primary care services in the state.

Subd. 2. **Apprenticeship program.** The commissioner of health shall distribute a grant to a nonprofit organization of community health centers for an apprenticeship program in federally qualified health centers operating in Minnesota. Grant money must be used to establish and fund ongoing costs for apprenticeship programs for medical assistants and dental assistants at federally qualified health center service delivery sites in Minnesota. An apprenticeship program funded under this section must be a 12-month program led by certified medical assistants and licensed dental assistants. Trainees for an apprenticeship program must be recruited from federally qualified health center staff and from the population in the geographic area served by the federally qualified health center.

Sec. 14. Minnesota Statutes 2022, section 245.4663, subdivision 4, is amended to read:

Subd. 4. **Allowable uses of grant funds.** A mental health provider must use grant funds received under this section for one or more of the following:

(1) to pay for direct supervision hours for interns and clinical trainees, in an amount up to $7,500 per intern or clinical trainee;

(2) to establish a program to provide supervision to multiple interns or clinical trainees; ~~or~~

(3) to pay licensing application and examination fees for clinical trainees~~.~~; or

(4) to provide a weekend training program for workers to become supervisors.

House Language UES2995-2

THE FOLLOWING SECTION WAS MOVED IN FROM UES2995-2, ARTICLE 7, SECTION 2, TO MATCH S2995-2, ARTICLE 5, SECTION 14

Sec. 2. Minnesota Statutes 2022, section 245.4663, subdivision 4, is amended to read:

Subd. 4. **Allowable uses of grant funds.** A mental health provider must use grant funds received under this section for one or more of the following:

(1) to pay for direct supervision hours or preceptorships for students, interns, and clinical trainees, in an amount up to $7,500 per student, intern, or clinical trainee;

(2) to establish a program to provide supervision to multiple students, interns, or clinical trainees; ~~or~~

(3) to pay licensing application and examination fees for clinical trainees~~.~~; or

(4) to provide a weekend training program for workers to become supervisors.

Sec. 15. **[245.4664] MENTAL HEALTH PROFESSIONAL SCHOLARSHIP GRANT PROGRAM.**

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

(b) "Mental health professional" means an individual with a qualification specified in section 245I.04, subdivision 2.

(c) "Underrepresented community" has the meaning given in section 148E.010, subdivision 20.

Subd. 2. **Grant program established.** The mental health professional scholarship program is established in the Department of Human Services to assist mental health providers in funding employee scholarships for master's degree-level education programs in order to create a pathway to becoming a mental health professional.

Subd. 3. **Provision of grants.** The commissioner of human services shall award grants to licensed or certified mental health providers who meet the criteria in subdivision 4 to provide tuition reimbursement for master's degree-level programs and certain related costs for individuals who have worked for the mental health provider for at least the past two years in one or more of the following roles:

(1) a mental health behavioral aide who meets a qualification in section 245I.04, subdivision 16;

(2) a mental health certified family peer specialist who meets the qualifications in section 245I.04, subdivision 12;

(3) a mental health certified peer specialist who meets the qualifications in section 245I.04, subdivision 10;

(4) a mental health practitioner who meets a qualification in section 245I.04, subdivision 4;

(5) a mental health rehabilitation worker who meets the qualifications in section 245I.04, subdivision 14;

(6) an individual employed in a role in which the individual provides face-to-face client services at a mental health center or certified community behavioral health center; or

(7) a staff person who provides care or services to residents of a residential treatment facility.

Subd. 4. **Eligibility.** In order to be eligible for a grant under this section, a mental health provider must:

(1) primarily provide at least 25 percent of the provider's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through

a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303; or

(2) primarily serve people from communities of color or underrepresented communities.

Subd. 5. **Request for proposals.** The commissioner must publish a request for proposals in the State Register specifying provider eligibility requirements, criteria for a qualifying employee scholarship program, provider selection criteria, documentation required for program participation, the maximum award amount, and methods of evaluation. The commissioner must publish additional requests for proposals each year in which funding is available for this purpose.

Subd. 6. **Application requirements.** An eligible provider seeking a grant under this section must submit an application to the commissioner. An application must contain a complete description of the employee scholarship program being proposed by the applicant, including the need for the mental health provider to enhance the education of its workforce, the process the mental health provider will use to determine which employees will be eligible for scholarships, any other money sources for scholarships, the amount of money sought for the scholarship program, a proposed budget detailing how money will be spent, and plans to retain eligible employees after completion of the education program.

Subd. 7. **Selection process.** The commissioner shall determine a maximum award amount for grants and shall select grant recipients based on the information provided in the grant application, including the demonstrated need for the applicant provider to enhance the education of its workforce, the proposed process to select employees for scholarships, the applicant's proposed budget, and other criteria as determined by the commissioner. The commissioner shall give preference to grant applicants who work in rural or culturally specific organizations.

Subd. 8. **Grant agreements.** Notwithstanding any law or rule to the contrary, grant money awarded to a grant recipient in a grant agreement does not lapse until the grant agreement expires.

Subd. 9. **Allowable uses of grant money.** A mental health provider receiving a grant under this section must use the grant money for one or more of the following:

(1) to provide employees with tuition reimbursement for a master's degree-level program in a discipline that will allow the employee to qualify as a mental health professional; or

(2) for resources and supports, such as child care and transportation, that allow an employee to attend a master's degree-level program specified in clause (1).

Subd. 10. **Reporting requirements.** A mental health provider receiving a grant under this section must submit an invoice for reimbursement and a report to the commissioner on a schedule determined by the commissioner and using a form supplied by the commissioner. The report must include the amount spent on scholarships; the number of employees who

Senate Language S2995-3

House Language UES2995-2

received scholarships; and, for each scholarship recipient, the recipient's name, current position, amount awarded, educational institution attended, name of the educational program, and expected or actual program completion date.

Sec. 16. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

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

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

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

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

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

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

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

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than

Sec. 7. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

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

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

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

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

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

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

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

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include adjustments to the projected rates that result in no greater than

Senate Language S2995-3

a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

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

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

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

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

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

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

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the

House Language UES2995-2

a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

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

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

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

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

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

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

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the

Senate Language S2995-3

total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

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

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

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

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

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

House Language UES2995-2

total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

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

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

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

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

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

Senate Language S2995-3

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

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

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

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

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

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

(6) geographic location.

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

Sec. 17. Minnesota Statutes 2022, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

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

House Language UES2995-2

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

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

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

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

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

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

(6) geographic location.

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

Sec. 8. Minnesota Statutes 2022, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

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

Senate Language S2995-3

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics. Effective for services delivered on or after January 1, 2024, the rates paid to critical access hospitals under this section must be adjusted to include the amount of any distributions under section 62J.692, subdivision 4, paragraph (a), that were not included in the rate adjustment described under section 256.969, subdivision 2b, paragraph (k).

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

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

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

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent

House Language UES2995-2

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics. Effective for services delivered on or after January 1, 2024, the rates paid to critical access hospitals under this section must be adjusted to include the amount of any distributions under section 62J.692, subdivision 4, paragraph (a), that were not included in the rate adjustment described under section 256.969, subdivision 2b, paragraph (k).

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

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

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

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent

Senate Language S2995-3

from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

Sec. 18. Minnesota Statutes 2022, section 297F.10, subdivision 1, is amended to read:

Subdivision 1. **Tax and use tax on cigarettes.** Revenue received from cigarette taxes, as well as related penalties, interest, license fees, and miscellaneous sources of revenue shall be deposited by the commissioner in the state treasury and credited as follows:

(1) $22,250,000 each year must be credited to the Academic Health Center special revenue fund hereby created and is annually appropriated to the Board of Regents at the University of Minnesota for Academic Health Center funding at the University of Minnesota; and

(2) ~~$3,937,000~~ $3,788,000 each year must be credited to the medical education and research costs account hereby created in the special revenue fund and is annually appropriated to the commissioner of health for distribution under section 62J.692, subdivision 4, paragraph (a); and

(3) the balance of the revenues derived from taxes, penalties, and interest (under this chapter) and from license fees and miscellaneous sources of revenue shall be credited to the general fund.

Sec. 19. **REPEALER.**

Minnesota Statutes 2022, sections 62J.692, subdivisions 4a, 7, and 7a; 137.38, subdivision 1; and 256B.69, subdivision 5c, are repealed.

House Language UES2995-2

from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

Sec. 9. Minnesota Statutes 2022, section 297F.10, subdivision 1, is amended to read:

Subdivision 1. **Tax and use tax on cigarettes.** Revenue received from cigarette taxes, as well as related penalties, interest, license fees, and miscellaneous sources of revenue shall be deposited by the commissioner in the state treasury and credited as follows:

(1) $22,250,000 each year must be credited to the Academic Health Center special revenue fund hereby created and is annually appropriated to the Board of Regents at the University of Minnesota for Academic Health Center funding at the University of Minnesota; and

(2) ~~$3,937,000~~ $3,788,000 each year must be credited to the medical education and research costs account hereby created in the special revenue fund and is annually appropriated to the commissioner of health for distribution under section 62J.692, subdivision 4, paragraph (a); and

(3) the balance of the revenues derived from taxes, penalties, and interest (under this chapter) and from license fees and miscellaneous sources of revenue shall be credited to the general fund.

Sec. 10. **REPEALER.**

Minnesota Statutes 2022, sections 62J.692, subdivisions 4a, 7, and 7a; 137.38, subdivision 1; and 256B.69, subdivision 5c, are repealed.