

3.42 ARTICLE 1
3.43 DEPARTMENT OF HUMAN SERVICES HEALTH CARE FINANCE

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3.3 DEPARTMENT OF HUMAN SERVICES HEALTH CARE FINANCE
3.4 Section 1. [62V.12] STATE-FUNDED COST-SHARING REDUCTIONS.
3.5 Subdivision 1. Establishment. (a) The board must develop and administer a state-funded
3.6 cost-sharing reduction program for eligible persons who enroll in a silver level qualified
3.7 health plan through MNsure. The board must implement the cost-sharing reduction program
3.8 for plan years beginning on or after January 1, 2027.
3.9 (b) For purposes of this section, an "eligible person" is an individual who meets the
3.10 eligibility criteria to receive a cost-sharing reduction under Code of Federal Regulations,
3.11 title 45, section 155.305(g).
3.12 Subd. 2. Reduction in cost-sharing. The cost-sharing reduction program must use state
3.13 money to reduce enrollee cost-sharing by increasing the actuarial value of silver level health
3.14 plans for eligible persons beyond the 73 percent value established in Code of Federal
3.15 Regulations, title 45, section 156.420(a)(3)(ii), to an actuarial value of 87 percent.
3.16 Subd. 3. Administration. The board, when administering the program, must:
3.17 (1) allow eligible persons to enroll in a silver level health plan with a state-funded
3.18 cost-sharing reduction;
3.19 (2) modify the MNsure shopping tool to display the total cost-sharing reduction benefit
3.20 available to individuals eligible under this section; and
3.21 (3) reimburse health carriers on a quarterly basis for the cost to the health plan providing
3.22 the state-funded cost-sharing reductions.
3.23 Sec. 2. Minnesota Statutes 2023 Supplement, section 256.9631, is amended to read:
3.24 256.9631 DIRECT PAYMENT SYSTEM ALTERNATIVE CARE DELIVERY
3.25 MODELS FOR MEDICAL ASSISTANCE AND MINNESOTACARE.
3.26 Subdivision 1. Direction to the commissioner. (a) The commissioner, in order to deliver
3.27 services to eligible individuals, achieve better health outcomes, and reduce the cost of health
3.28 care for the state, shall develop an implementation plan plans for a direct payment system
3.29 to deliver services to eligible individuals in order to achieve better health outcomes and
3.30 reduce the cost of health care for the state. Under this system, at least three care delivery
3.31 models that:
4.1 (1) are alternatives to the use of commercial managed care plans to deliver health care
4.2 to Minnesota health care program enrollees; and
4.3 (2) do not shift financial risk to nongovernmental entities.
4.4 (b) One of the alternative models must be a direct payment system under which eligible
4.5 individuals must receive services through the medical assistance fee-for-service system,

- 4.6 county-based purchasing plans, ~~or~~ and county-owned health maintenance organizations. At
 4.7 least one additional model must include county-based purchasing plans and county-owned
 4.8 health maintenance organizations in their design, and must allow these entities to deliver
 4.9 care in geographic areas on a single plan basis, if:
- 4.10 (1) these entities contract with all providers that agree to contract terms for network
 4.11 participation; and
- 4.12 (2) the commissioner of human services determines that an entity's provider network is
 4.13 adequate to ensure enrollee access and choice.
- 4.14 (c) Before determining the alternative models for which implementation plans will be
 4.15 developed, the commissioner shall consult with the chairs and ranking minority members
 4.16 of the legislative committees with jurisdiction over health care finance and policy.
- 4.17 (d) The commissioner shall present ~~an~~ implementation ~~plan~~ plans for the ~~direct payment~~
 4.18 ~~system~~ selected models to the chairs and ranking minority members of the legislative
 4.19 committees with jurisdiction over health care finance and policy by January 15, 2026. The
 4.20 commissioner may contract for technical assistance in developing the implementation ~~plan~~
 4.21 plans and conducting related studies and analyses.
- 4.22 (b) ~~For the purposes of the direct payment system, the commissioner shall make the~~
 4.23 ~~following assumptions:~~
- 4.24 (1) ~~health care providers are reimbursed directly for all medical assistance covered~~
 4.25 ~~services provided to eligible individuals, using the fee-for-service payment methods specified~~
 4.26 ~~in chapters 256, 256B, 256R, and 256S;~~
- 4.27 (2) ~~payments to a qualified hospital provider are equivalent to the payments that would~~
 4.28 ~~have been received based on managed care direct payment arrangements. If necessary, a~~
 4.29 ~~qualified hospital provider may use a county-owned health maintenance organization to~~
 4.30 ~~receive direct payments as described in section 256B.1973; and~~
- 4.31 (3) ~~county-based purchasing plans and county-owned health maintenance organizations~~
 4.32 ~~must be reimbursed at the capitation rate determined under sections 256B.69 and 256B.692.~~
- 5.1 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
 5.2 meanings given.
- 5.3 (b) "Eligible individuals" means ~~qualified all medical assistance enrollees, defined as~~
 5.4 ~~persons eligible for medical assistance as families and children and adults without children~~
 5.5 ~~and MinnesotaCare enrollees.~~
- 5.6 (c) "Minnesota health care programs" means the medical assistance and MinnesotaCare
 5.7 programs.

- 5.8 ~~(c)~~ (d) "Qualified hospital provider" means a nonstate government teaching hospital
 5.9 with high medical assistance utilization and a level 1 trauma center, and all of the hospital's
 5.10 owned or affiliated health care professionals, ambulance services, sites, and clinics.
- 5.11 Subd. 3. **Implementation plan plans.** (a) ~~The~~ Each implementation plan must include:
- 5.12 (1) a timeline for the development and recommended implementation date of the ~~direct~~
 5.13 ~~payment system~~ alternative model. In recommending a timeline, the commissioner must
 5.14 consider:
- 5.15 (i) timelines required by the existing contracts with managed care plans and county-based
 5.16 purchasing plans to sunset existing delivery models;
- 5.17 (ii) in counties that choose to operate a county-based purchasing plan under section
 5.18 256B.692, timelines for any new procurements required for those counties to establish a
 5.19 new county-based purchasing plan or participate in an existing county-based purchasing
 5.20 plan;
- 5.21 (iii) in counties that choose to operate a county-owned health maintenance organization
 5.22 under section 256B.69, timelines for any new procurements required for those counties to
 5.23 establish a new county-owned health maintenance organization or to continue serving
 5.24 enrollees through an existing county-owned health maintenance organization; and
- 5.25 (iv) a recommendation on whether the commissioner should contract with a third-party
 5.26 administrator to administer the ~~direct payment system~~ alternative model, and the timeline
 5.27 needed for procuring an administrator;
- 5.28 (2) the procedures to be used to ensure continuity of care for enrollees who transition
 5.29 from managed care to fee-for-service and any administrative resources needed to carry out
 5.30 these procedures;
- 5.31 (3) recommended quality measures for health care service delivery;
- 6.1 (4) any changes to fee-for-service payment rates that the commissioner determines are
 6.2 necessary to ensure provider access and high-quality care and to reduce health disparities;
- 6.3 (5) recommendations on ensuring effective care coordination under the ~~direct payment~~
 6.4 ~~system~~ alternative model, especially for enrollees who:
- 6.5 (i) are age 65 or older, blind, or have disabilities;
- 6.6 (ii) have complex medical conditions, ~~who~~;
- 6.7 (iii) face socioeconomic barriers to receiving care, ~~or who~~; or
- 6.8 (iv) are from underserved populations that experience health disparities;
- 6.9 (6) recommendations on ~~whether the direct payment system should provide supplemental~~
 6.10 ~~payments~~ payment arrangements for care coordination, including:

- 6.11 (i) the provider types eligible for supplemental care coordination payments;
- 6.12 (ii) procedures to coordinate supplemental care coordination payments with existing
- 6.13 supplemental or cost-based payment methods or to replace these existing methods; and
- 6.14 (iii) procedures to align care coordination initiatives funded through supplemental
- 6.15 payments under this section the alternative model with existing care coordination initiatives;
- 6.16 (7) recommendations on whether the direct payment system alternative model should
- 6.17 include funding to providers for outreach initiatives to patients who, because of mental
- 6.18 illness, homelessness, or other circumstances, are unlikely to obtain needed care and
- 6.19 treatment;
- 6.20 (8) recommendations for a supplemental payment to qualified hospital providers to offset
- 6.21 any potential revenue losses resulting from the shift from managed care payments; and
- 6.22 ~~(9) recommendations on whether and how the direct payment system should be expanded~~
- 6.23 ~~to deliver services and care coordination to medical assistance enrollees who are age 65 or~~
- 6.24 ~~older, are blind, or have a disability and to persons enrolled in MinnesotaCare; and~~
- 6.25 ~~(10) (9) recommendations for statutory changes necessary to implement the direct~~
- 6.26 ~~payment system alternative model.~~
- 6.27 (b) In developing the each implementation plan, the commissioner shall:
- 6.28 (1) calculate the projected cost of a direct payment system the alternative model relative
- 6.29 to the cost of the current system;
- 6.30 (2) assess gaps in care coordination under the current medical assistance and
- 6.31 MinnesotaCare programs;
- 7.1 (3) evaluate the effectiveness of approaches other states have taken to coordinate care
- 7.2 under a fee-for-service system, including the coordination of care provided to persons who
- 7.3 are age 65 or older, are blind, or have disabilities;
- 7.4 (4) estimate the loss of revenue and cost savings from other payment enhancements
- 7.5 based on managed care plan directed payments and pass-throughs;
- 7.6 (5) estimate cost trends under a direct payment system the alternative model for managed
- 7.7 care payments to county-based purchasing plans and county-owned health maintenance
- 7.8 organizations;
- 7.9 (6) estimate the impact of a direct payment system the alternative model on other revenue,
- 7.10 including taxes, surcharges, or other federally approved in lieu of services and on other
- 7.11 arrangements allowed under managed care;
- 7.12 (7) consider allowing eligible individuals to opt out of managed care as an alternative
- 7.13 approach;

3.44 Section 1. Minnesota Statutes 2022, section 256.9657, is amended by adding a subdivision
3.45 to read:

3.46 Subd. 2a. **Teaching hospital surcharge.** (a) Each teaching hospital shall pay to the
3.47 medical assistance account a surcharge equal to 0.01 percent of net non-Medicare patient
3.48 care revenue. The initial surcharge must be paid 60 days after both this subdivision and
4.1 section 256.969, subdivision 2g, have received federal approval, and subsequent surcharge
4.2 payments must be made annually in the form and manner specified by the commissioner.

4.3 (b) The commissioner shall use revenue from the surcharge only to pay the nonfederal
4.4 share of the medical assistance supplemental payments described in section 256.969,
4.5 subdivision 2g, and to supplement, and not supplant, medical assistance reimbursement to
4.6 teaching hospitals. The surcharge must comply with Code of Federal Regulations, title 42,
4.7 section 433.68.

4.8 (c) For purposes of this subdivision, "teaching hospital" means any Minnesota hospital,
4.9 except facilities of the federal Indian Health Service and regional treatment centers, with a
4.10 Centers for Medicare and Medicaid Services designation of "teaching hospital" as reported
4.11 on form CMS-2552-10, worksheet S-2, line 56, that is eligible for reimbursement under
4.12 section 256.969, subdivision 2g.

4.13 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval
4.14 of this section, the amendment in this act to section 256.969, subdivision 2b, and section
4.15 256.969, subdivision 2g, whichever is later. The commissioner of human services shall
4.16 notify the revisor of statutes when federal approval is obtained.

7.14 ~~(8) assess the feasibility of a medical assistance outpatient prescription drug benefit~~
7.15 ~~carve-out under section 256B.69, subdivision 6d, and in consultation with the commissioners~~
7.16 ~~of commerce and health, assess the feasibility of including MinnesotaCare enrollees and~~
7.17 ~~private sector enrollees of health plan companies in the drug benefit carve-out. The~~
7.18 ~~assessment of feasibility must address and include recommendations related to the process~~
7.19 ~~and terms by which the commissioner would contract with health plan companies to~~
7.20 ~~administer prescription drug benefits and develop and manage a drug formulary, and the~~
7.21 ~~impact of the drug benefit carve-out on health care providers, including small pharmacies;~~

7.22 ~~(9)~~ (8) consult with the commissioners of health and commerce and the contractor or
7.23 contractors analyzing the Minnesota Health Plan under section 19 and other health reform
7.24 models on plan design and assumptions; and

7.25 ~~(10)~~ (9) conduct other analyses necessary to develop the implementation plan.

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

7.27 Sec. 3. Minnesota Statutes 2022, section 256.9657, is amended by adding a subdivision
7.28 to read:

7.29 Subd. 2a. **Teaching hospital surcharge.** (a) Each teaching hospital shall pay to the
7.30 medical assistance account a surcharge equal to 0.01 percent of net non-Medicare patient
7.31 care revenue. The initial surcharge must be paid 60 days after both this subdivision and
8.1 section 256.969, subdivision 2g, have received federal approval, and subsequent surcharge
8.2 payments must be made annually in the form and manner specified by the commissioner.

8.3 (b) The commissioner shall use revenue from the surcharge only to pay the nonfederal
8.4 share of the medical assistance supplemental payments described in section 256.969,
8.5 subdivision 2g, and to supplement, and not supplant, medical assistance reimbursement to
8.6 teaching hospitals. The surcharge must comply with Code of Federal Regulations, title 42,
8.7 section 433.68.

8.8 (c) For purposes of this subdivision, "teaching hospital" means any Minnesota hospital,
8.9 except facilities of the federal Indian Health Service and regional treatment centers, with a
8.10 Centers for Medicare and Medicaid Services designation of "teaching hospital" as reported
8.11 on form CMS-2552-10, worksheet S-2, line 56, that is eligible for reimbursement under
8.12 section 256.969, subdivision 2g.

8.13 **EFFECTIVE DATE.** This section is effective the later of January 1, 2025, or federal
8.14 approval of this section and sections 4 and 5. The commissioner of human services shall
8.15 notify the revisor of statutes when federal approval is obtained.

4.17 Sec. 2. Minnesota Statutes 2023 Supplement, section 256.969, subdivision 2b, is amended
4.18 to read:

4.19 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
4.20 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
4.21 to the following:

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

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

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

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

4.30 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
4.31 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
4.32 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
5.1 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
5.2 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
5.3 years are updated, a Minnesota long-term hospital's base year shall remain within the same
5.4 period as other hospitals.

5.5 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
5.6 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
5.7 area, except for the hospitals paid under the methodologies described in paragraph (a),
5.8 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
5.9 manner similar to Medicare. The base year or years for the rates effective November 1,
5.10 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,
5.11 ensuring that the total aggregate payments under the rebased system are equal to the total
5.12 aggregate payments that were made for the same number and types of services in the base
5.13 year. Separate budget neutrality calculations shall be determined for payments made to
5.14 critical access hospitals and payments made to hospitals paid under the DRG system. Only
5.15 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being
5.16 rebased during the entire base period shall be incorporated into the budget neutrality
5.17 calculation.

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

8.16 Sec. 4. Minnesota Statutes 2023 Supplement, section 256.969, subdivision 2b, is amended
8.17 to read:

8.18 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
8.19 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
8.20 to the following:

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

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

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

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

8.29 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
8.30 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
8.31 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
8.32 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
9.1 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
9.2 years are updated, a Minnesota long-term hospital's base year shall remain within the same
9.3 period as other hospitals.

9.4 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
9.5 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
9.6 area, except for the hospitals paid under the methodologies described in paragraph (a),
9.7 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
9.8 manner similar to Medicare. The base year or years for the rates effective November 1,
9.9 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,
9.10 ensuring that the total aggregate payments under the rebased system are equal to the total
9.11 aggregate payments that were made for the same number and types of services in the base
9.12 year. Separate budget neutrality calculations shall be determined for payments made to
9.13 critical access hospitals and payments made to hospitals paid under the DRG system. Only
9.14 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being
9.15 rebased during the entire base period shall be incorporated into the budget neutrality
9.16 calculation.

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

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

5.28 (1) pediatric services;

5.29 (2) behavioral health services;

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

5.31 (4) transplant services;

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

6.1 (6) outlier admissions;

6.2 (7) low-volume providers; and

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

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

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

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

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

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

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

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

9.27 (1) pediatric services;

9.28 (2) behavioral health services;

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

9.30 (4) transplant services;

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

9.33 (6) outlier admissions;

10.1 (7) low-volume providers; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.10 (6) geographic location.

8.11 (k) Subject to section 256.969, subdivision 2g, paragraph (i), effective for discharges
8.12 occurring on or after January 1, 2024, the rates paid to hospitals described in paragraph (a),
8.13 clauses (2) to (4), must include a rate factor specific to each hospital that qualifies for a
8.14 medical education and research cost distribution under section 62J.692, subdivision 4,
8.15 paragraph (a).

8.16 EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval
8.17 of this section, section 256.969, subdivision 2g, and the teaching hospital surcharge described
8.18 in section 256.9657, subdivision 2a, whichever is later. The commissioner of human services
8.19 shall notify the revisor of statutes when federal approval is obtained.

8.20 Sec. 3. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to
8.21 read:

8.22 Subd. 2g. Annual supplemental payments; direct and indirect physician graduate
8.23 medical education. (a) For discharges occurring on or after January 1, 2025, the
8.24 commissioner shall determine and pay annual supplemental payments to all eligible hospitals
8.25 as provided in this subdivision for direct and indirect physician graduate medical education
8.26 cost reimbursement. A hospital must be an eligible hospital to receive an annual supplemental
8.27 payment under this subdivision.

8.28 (b) The commissioner must use the following information to calculate the total cost of
8.29 direct graduate medical education incurred by each eligible hospital:

8.30 (1) the total allowable direct graduate medical education cost, as calculated by adding
8.31 form CMS-2552-10, worksheet B, part 1, columns 21 and 22, line 202; and

9.1 (2) the Medicaid share of total allowable direct graduate medical education cost
9.2 percentage, representing the allocation of total graduate medical education costs to Medicaid
9.3 based on the share of all Medicaid inpatient days, as reported on form CMS-2552-10,

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

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

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

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

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

12.10 (6) geographic location.

12.11 (k) Subject to section 256.969, subdivision 2g, paragraph (i), effective for discharges
12.12 occurring on or after January 1, 2024, the rates paid to hospitals described in paragraph (a),
12.13 clauses (2) to (4), must include a rate factor specific to each hospital that qualifies for a
12.14 medical education and research cost distribution under section 62J.692, subdivision 4,
12.15 paragraph (a).

12.16 EFFECTIVE DATE. This section is effective the later of January 1, 2025, or federal
12.17 approval of this section and sections 3 and 5. The commissioner of human services shall
12.18 notify the revisor of statutes when federal approval is obtained.

12.19 Sec. 5. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to
12.20 read:

12.21 Subd. 2g. Annual supplemental payments; direct and indirect physician graduate
12.22 medical education. (a) For discharges occurring on or after January 1, 2025, the
12.23 commissioner shall determine and pay annual supplemental payments to all eligible hospitals
12.24 as provided in this subdivision for direct and indirect physician graduate medical education
12.25 cost reimbursement. A hospital must be an eligible hospital to receive an annual supplemental
12.26 payment under this subdivision.

12.27 (b) The commissioner must use the following information to calculate the total cost of
12.28 direct graduate medical education incurred by each eligible hospital:

12.29 (1) the total allowable direct graduate medical education cost, as calculated by adding
12.30 form CMS-2552-10, worksheet B, part 1, columns 21 and 22, line 202; and

12.31 (2) the Medicaid share of total allowable direct graduate medical education cost
12.32 percentage, representing the allocation of total graduate medical education costs to Medicaid
13.1 based on the share of all Medicaid inpatient days, as reported on form CMS-2552-10,

9.4 worksheets S-2 and S-3, divided by the hospital's total inpatient days, as reported on
9.5 worksheet S-3.

9.6 (c) The commissioner may obtain the information in paragraph (b) from an eligible
9.7 hospital upon request by the commissioner or from the eligible hospital's most recently filed
9.8 form CMS-2552-10.

9.9 (d) The commissioner must use the following information to calculate the total allowable
9.10 indirect cost of graduate medical education incurred by each eligible hospital:

9.11 (1) for eligible hospitals that are not children's hospitals, the indirect graduate medical
9.12 education amount attributable to Medicaid, calculated based on form CMS-2552-10,
9.13 worksheet E, part A, including:

9.14 (i) the Medicare indirect medical education formula, using Medicaid variables;

9.15 (ii) Medicaid payments for inpatient services under fee-for-service and managed care,
9.16 as determined by the commissioner in consultation with each eligible hospital;

9.17 (iii) total inpatient beds available, as reported on form CMS-2552-10, worksheet E, part
9.18 A, line 4; and

9.19 (iv) full-time employees, as determined by adding form CMS-2552-10, worksheet E,
9.20 part A, lines 10 and 11; and

9.21 (2) for eligible hospitals that are children's hospitals:

9.22 (i) the Medicare indirect medical education formula, using Medicaid variables;

9.23 (ii) Medicaid payments for inpatient services under fee-for-service and managed care,
9.24 as determined by the commissioner in consultation with each eligible hospital;

9.25 (iii) total inpatient beds available, as reported on form CMS-2552-10, worksheet S-3,
9.26 part I; and

9.27 (iv) full-time equivalent interns and residents, as determined by adding form
9.28 CMS-2552-10, worksheet E-4, lines 6, 10.01, and 15.01.

9.29 (e) The commissioner shall determine each eligible hospital's maximum allowable
9.30 Medicaid direct graduate medical education supplemental payment amount by calculating
9.31 the sum of:

10.1 (1) the total allowable direct graduate medical education costs determined under paragraph
10.2 (b), clause (1), multiplied by the Medicaid share of total allowable direct graduate medical
10.3 education cost percentage in paragraph (b), clause (2); and

10.4 (2) the total allowable direct graduate medical education costs determined under paragraph
10.5 (b), clause (1), multiplied by the most recently updated Medicaid utilization percentage
10.6 from form CMS-2552-10, as submitted to Medicare by each eligible hospital.

13.2 worksheets S-2 and S-3, divided by the hospital's total inpatient days, as reported on
13.3 worksheet S-3.

13.4 (c) The commissioner may obtain the information in paragraph (b) from an eligible
13.5 hospital upon request by the commissioner or from the eligible hospital's most recently filed
13.6 form CMS-2552-10.

13.7 (d) The commissioner must use the following information to calculate the total allowable
13.8 indirect cost of graduate medical education incurred by each eligible hospital:

13.9 (1) for eligible hospitals that are not children's hospitals, the indirect graduate medical
13.10 education amount attributable to Medicaid, calculated based on form CMS-2552-10,
13.11 worksheet E, part A, including:

13.12 (i) the Medicare indirect medical education formula, using Medicaid variables;

13.13 (ii) Medicaid payments for inpatient services under fee-for-service and managed care,
13.14 as determined by the commissioner in consultation with each eligible hospital;

13.15 (iii) total inpatient beds available, as reported on form CMS-2552-10, worksheet E, part
13.16 A, line 4; and

13.17 (iv) full-time employees, as determined by adding form CMS-2552-10, worksheet E,
13.18 part A, lines 10 and 11; and

13.19 (2) for eligible hospitals that are children's hospitals:

13.20 (i) the Medicare indirect medical education formula, using Medicaid variables;

13.21 (ii) Medicaid payments for inpatient services under fee-for-service and managed care,
13.22 as determined by the commissioner in consultation with each eligible hospital;

13.23 (iii) total inpatient beds available, as reported on form CMS-2552-10, worksheet S-3,
13.24 part I; and

13.25 (iv) full-time equivalent interns and residents, as determined by adding form
13.26 CMS-2552-10, worksheet E-4, lines 6, 10.01, and 15.01.

13.27 (e) The commissioner shall determine each eligible hospital's maximum allowable
13.28 Medicaid direct graduate medical education supplemental payment amount by calculating
13.29 the sum of:

14.1 (1) the total allowable direct graduate medical education costs determined under paragraph
14.2 (b), clause (1), multiplied by the Medicaid share of total allowable direct graduate medical
14.3 education cost percentage in paragraph (b), clause (2); and

14.4 (2) the total allowable direct graduate medical education costs determined under paragraph
14.5 (b), clause (1), multiplied by the most recently updated Medicaid utilization percentage
14.6 from form CMS-2552-10, as submitted to Medicare by each eligible hospital.

10.7 (f) The commissioner shall determine each eligible hospital's indirect graduate medical
10.8 education supplemental payment amount by multiplying the total allowable indirect cost
10.9 of graduate medical education amount calculated in paragraph (d) by:
10.10 (1) 0.95 for prospective payment system, for hospitals that are not children's hospitals
10.11 and have fewer than 50 full-time equivalent trainees;
10.12 (2) 1.0 for prospective payment system, for hospitals that are not children's hospitals
10.13 and have equal to or greater than 50 full-time equivalent trainees; and
10.14 (3) 1.05 for children's hospitals.
10.15 (g) An eligible hospital's annual supplemental payment under this subdivision equals
10.16 the sum of the amount calculated for the eligible hospital under paragraph (e) and the amount
10.17 calculated for the eligible hospital under paragraph (f).
10.18 (h) The annual supplemental payments under this subdivision are contingent upon federal
10.19 approval and must conform with the requirements for permissible supplemental payments
10.20 for direct and indirect graduate medical education under all applicable federal laws.
10.21 (i) An eligible hospital is only eligible for reimbursement under section 62J.692 for
10.22 nonphysician graduate medical education training costs that are not accounted for in the
10.23 calculation of an annual supplemental payment under this section. An eligible hospital must
10.24 not accept reimbursement under section 62J.692 for physician graduate medical education
10.25 training costs that are accounted for in the calculation of an annual supplemental payment
10.26 under this section.
10.27 (j) For purposes of this subdivision, "children's hospital" means a Minnesota hospital
10.28 designated as a children's hospital under Medicare.
10.29 (k) For purposes of this subdivision, "eligible hospital" means a hospital located in
10.30 Minnesota:
10.31 (1) participating in Minnesota's medical assistance program;
11.1 (2) that has received fee-for-service medical assistance payments in the payment year;
11.2 and
11.3 (3) that is either:
11.4 (i) eligible to receive graduate medical education payments from the Medicare program
11.5 under Code of Federal Regulations, title 42, section 413.75; or
11.6 (ii) a children's hospital.
11.7 **EFFECTIVE DATE.** This section is effective January 1, 2025, or **upon** federal approval
11.8 of this section, the amendment in this act to section 256.969, subdivision 2b, and the teaching
11.9 hospital surcharge described in section 256.9657, subdivision 2a, whichever is later. The

14.7 (f) The commissioner shall determine each eligible hospital's indirect graduate medical
14.8 education supplemental payment amount by multiplying the total allowable indirect cost
14.9 of graduate medical education amount calculated in paragraph (d) by:
14.10 (1) 0.95 for prospective payment system, for hospitals that are not children's hospitals
14.11 and have fewer than 50 full-time equivalent trainees;
14.12 (2) 1.0 for prospective payment system, for hospitals that are not children's hospitals
14.13 and have equal to or greater than 50 full-time equivalent trainees; and
14.14 (3) 1.05 for children's hospitals.
14.15 (g) An eligible hospital's annual supplemental payment under this subdivision equals
14.16 the sum of the amount calculated for the eligible hospital under paragraph (e) and the amount
14.17 calculated for the eligible hospital under paragraph (f).
14.18 (h) The annual supplemental payments under this subdivision are contingent upon federal
14.19 approval and must conform with the requirements for permissible supplemental payments
14.20 for direct and indirect graduate medical education under all applicable federal laws.
14.21 (i) An eligible hospital is only eligible for reimbursement under section 62J.692 for
14.22 nonphysician graduate medical education training costs that are not accounted for in the
14.23 calculation of an annual supplemental payment under this section. An eligible hospital must
14.24 not accept reimbursement under section 62J.692 for physician graduate medical education
14.25 training costs that are accounted for in the calculation of an annual supplemental payment
14.26 under this section.
14.27 (j) For purposes of this subdivision, "children's hospital" means a Minnesota hospital
14.28 designated as a children's hospital under Medicare.
14.29 (k) For purposes of this subdivision, "eligible hospital" means a hospital located in
14.30 Minnesota:
14.31 (1) participating in Minnesota's medical assistance program;
15.1 (2) that has received fee-for-service medical assistance payments in the payment year;
15.2 and
15.3 (3) that is either:
15.4 (i) eligible to receive graduate medical education payments from the Medicare program
15.5 under Code of Federal Regulations, title 42, section 413.75; or
15.6 (ii) a children's hospital.
15.7 **EFFECTIVE DATE.** This section is effective **the later of** January 1, 2025, or federal
15.8 approval of this section and **sections 3 and 4.** The commissioner of human services shall
15.9 notify the revisor of statutes when federal approval is obtained.

11.10 commissioner of human services shall notify the revisor of statutes when federal approval
11.11 is obtained.

11.12 Sec. 4. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to
11.13 read:

11.14 Subd. 32. **Biological products for cell and gene therapy.** (a) Effective July 1, 2024,
11.15 the commissioner shall provide separate reimbursement to hospitals for biological products
11.16 provided in the inpatient hospital setting as part of cell or gene therapy to treat rare diseases,
11.17 as defined in United States Code, title 21, section 360bb. This payment must be separate
11.18 from the diagnostic related group reimbursement for the inpatient admission or discharge
11.19 associated with a stay during which the patient received a product subject to this paragraph.

11.20 (b) The commissioner shall establish the separate reimbursement rate for biological
11.21 products provided under paragraph (a) based on the methodology used for drugs administered
11.22 in an outpatient setting under section 256B.0625, subdivision 13e, paragraph (e).

11.23 (c) Upon necessary federal approval of documentation required to enter into a value-based
11.24 arrangement under section 256B.0625, subdivision 13k, a drug manufacturer must enter
11.25 into a value-based arrangement with the commissioner in order for a biological product
11.26 provided in the inpatient hospital setting as part of cell or gene therapy to treat rare diseases
11.27 to remain paid under paragraph (a). Any such value-based arrangement that replaces the
11.28 payment in paragraph (a) will be effective 120 days after the date of the necessary federal
11.29 approval required to enter into the value-based arrangement under section 256B.0625,
11.30 subdivision 13k.

11.31 **EFFECTIVE DATE.** This section is effective July 1, 2024.

12.1 Sec. 5. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13e, as
12.2 amended by Laws 2024, chapter 85, section 66, is amended to read:

12.3 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
12.4 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the
12.5 usual and customary price charged to the public. The usual and customary price means the
12.6 lowest price charged by the provider to a patient who pays for the prescription by cash,
12.7 check, or charge account and includes prices the pharmacy charges to a patient enrolled in
12.8 a prescription savings club or prescription discount club administered by the pharmacy or
12.9 pharmacy chain. The amount of payment basis must be reduced to reflect all discount
12.10 amounts applied to the charge by any third-party provider/insurer agreement or contract for
12.11 submitted charges to medical assistance programs. The net submitted charge may not be
12.12 greater than the patient liability for the service. The professional dispensing fee shall be
12.13 ~~\$10.77~~ \$11.55 for prescriptions filled with legend drugs meeting the definition of "covered
12.14 outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The
12.15 dispensing fee for intravenous solutions that must be compounded by the pharmacist shall

HOUSE ARTICLE 1, SECTION 6, WAS MOVED TO MATCH SENATE
ARTICLE 2, SECTION 4.

15.25 Sec. 7. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13e, as
15.26 amended by Laws 2024, chapter 85, section 66, is amended to read:

15.27 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
15.28 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the
15.29 usual and customary price charged to the public. The usual and customary price means the
15.30 lowest price charged by the provider to a patient who pays for the prescription by cash,
15.31 check, or charge account and includes prices the pharmacy charges to a patient enrolled in
15.32 a prescription savings club or prescription discount club administered by the pharmacy or
16.1 pharmacy chain. The amount of payment basis must be reduced to reflect all discount
16.2 amounts applied to the charge by any third-party provider/insurer agreement or contract for
16.3 submitted charges to medical assistance programs. The net submitted charge may not be
16.4 greater than the patient liability for the service. The professional dispensing fee shall be
16.5 ~~\$10.77~~ \$11.55 for prescriptions filled with legend drugs meeting the definition of "covered
16.6 outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The
16.7 dispensing fee for intravenous solutions that must be compounded by the pharmacist shall

12.16 be ~~\$10.77~~ \$11.55 per claim. The professional dispensing fee for prescriptions filled with
12.17 over-the-counter drugs meeting the definition of covered outpatient drugs shall be ~~\$10.77~~
12.18 \$11.55 for dispensed quantities equal to or greater than the number of units contained in
12.19 the manufacturer's original package. The professional dispensing fee shall be prorated based
12.20 on the percentage of the package dispensed when the pharmacy dispenses a quantity less
12.21 than the number of units contained in the manufacturer's original package. The pharmacy
12.22 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered
12.23 outpatient drugs shall be \$3.65 for quantities equal to or greater than the number of units
12.24 contained in the manufacturer's original package and shall be prorated based on the
12.25 percentage of the package dispensed when the pharmacy dispenses a quantity less than the
12.26 number of units contained in the manufacturer's original package. The National Average
12.27 Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug.
12.28 For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient
12.29 cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for
12.30 a provider participating in the federal 340B Drug Pricing Program shall be either the 340B
12.31 Drug Pricing Program ceiling price established by the Health Resources and Services
12.32 Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as
12.33 the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in
12.34 the United States, not including prompt pay or other discounts, rebates, or reductions in
12.35 price, for the most recent month for which information is available, as reported in wholesale
12.36 price guides or other publications of drug or biological pricing data. The maximum allowable
13.1 cost of a multisource drug may be set by the commissioner and it shall be comparable to
13.2 the actual acquisition cost of the drug product and no higher than the NADAC of the generic
13.3 product. Establishment of the amount of payment for drugs shall not be subject to the
13.4 requirements of the Administrative Procedure Act.

13.5 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
13.6 an automated drug distribution system meeting the requirements of section 151.58, or a
13.7 packaging system meeting the packaging standards set forth in Minnesota Rules, part
13.8 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
13.9 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
13.10 retrospectively billing pharmacy must submit a claim only for the quantity of medication
13.11 used by the enrolled recipient during the defined billing period. A retrospectively billing
13.12 pharmacy must use a billing period not less than one calendar month or 30 days.

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

13.18 (d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC
13.19 of the generic product or the maximum allowable cost established by the commissioner
13.20 unless prior authorization for the brand name product has been granted according to the
13.21 criteria established by the Drug Formulary Committee as required by subdivision 13f,

16.8 be ~~\$10.77~~ \$11.55 per claim. The professional dispensing fee for prescriptions filled with
16.9 over-the-counter drugs meeting the definition of covered outpatient drugs shall be ~~\$10.77~~
16.10 \$11.55 for dispensed quantities equal to or greater than the number of units contained in
16.11 the manufacturer's original package. The professional dispensing fee shall be prorated based
16.12 on the percentage of the package dispensed when the pharmacy dispenses a quantity less
16.13 than the number of units contained in the manufacturer's original package. The pharmacy
16.14 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered
16.15 outpatient drugs shall be \$3.65 for quantities equal to or greater than the number of units
16.16 contained in the manufacturer's original package and shall be prorated based on the
16.17 percentage of the package dispensed when the pharmacy dispenses a quantity less than the
16.18 number of units contained in the manufacturer's original package. The National Average
16.19 Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug.
16.20 For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient
16.21 cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for
16.22 a provider participating in the federal 340B Drug Pricing Program shall be either the 340B
16.23 Drug Pricing Program ceiling price established by the Health Resources and Services
16.24 Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as
16.25 the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in
16.26 the United States, not including prompt pay or other discounts, rebates, or reductions in
16.27 price, for the most recent month for which information is available, as reported in wholesale
16.28 price guides or other publications of drug or biological pricing data. The maximum allowable
16.29 cost of a multisource drug may be set by the commissioner and it shall be comparable to
16.30 the actual acquisition cost of the drug product and no higher than the NADAC of the generic
16.31 product. Establishment of the amount of payment for drugs shall not be subject to the
16.32 requirements of the Administrative Procedure Act.

16.33 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
16.34 an automated drug distribution system meeting the requirements of section 151.58, or a
16.35 packaging system meeting the packaging standards set forth in Minnesota Rules, part
16.36 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
17.1 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
17.2 retrospectively billing pharmacy must submit a claim only for the quantity of medication
17.3 used by the enrolled recipient during the defined billing period. A retrospectively billing
17.4 pharmacy must use a billing period not less than one calendar month or 30 days.

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

17.10 (d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC
17.11 of the generic product or the maximum allowable cost established by the commissioner
17.12 unless prior authorization for the brand name product has been granted according to the
17.13 criteria established by the Drug Formulary Committee as required by subdivision 13f,

13.22 paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in
13.23 a manner consistent with section 151.21, subdivision 2.

13.24 (e) The basis for determining the amount of payment for drugs administered in an
13.25 outpatient setting shall be the lower of the usual and customary cost submitted by the
13.26 provider, 106 percent of the average sales price as determined by the United States
13.27 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
13.28 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
13.29 set by the commissioner. If average sales price is unavailable, the amount of payment must
13.30 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
13.31 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
13.32 The commissioner shall discount the payment rate for drugs obtained through the federal
13.33 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an
13.34 outpatient setting shall be made to the administering facility or practitioner. A retail or
14.1 specialty pharmacy dispensing a drug for administration in an outpatient setting is not
14.2 eligible for direct reimbursement.

14.3 (f) The commissioner may establish maximum allowable cost rates for specialty pharmacy
14.4 products that are lower than the ingredient cost formulas specified in paragraph (a). The
14.5 commissioner may require individuals enrolled in the health care programs administered
14.6 by the department to obtain specialty pharmacy products from providers with whom the
14.7 commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are
14.8 defined as those used by a small number of recipients or recipients with complex and chronic
14.9 diseases that require expensive and challenging drug regimens. Examples of these conditions
14.10 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C,
14.11 growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of
14.12 cancer. Specialty pharmaceutical products include injectable and infusion therapies,
14.13 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that
14.14 require complex care. The commissioner shall consult with the Formulary Committee to
14.15 develop a list of specialty pharmacy products subject to maximum allowable cost
14.16 reimbursement. In consulting with the Formulary Committee in developing this list, the
14.17 commissioner shall take into consideration the population served by specialty pharmacy
14.18 products, the current delivery system and standard of care in the state, and access to care
14.19 issues. The commissioner shall have the discretion to adjust the maximum allowable cost
14.20 to prevent access to care issues.

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

14.23 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey
14.24 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient
14.25 drugs under medical assistance. The commissioner shall ensure that the vendor has prior
14.26 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the
14.27 department to dispense outpatient prescription drugs to fee-for-service members must
14.28 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under

17.14 paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in
17.15 a manner consistent with section 151.21, subdivision 2.

17.16 (e) The basis for determining the amount of payment for drugs administered in an
17.17 outpatient setting shall be the lower of the usual and customary cost submitted by the
17.18 provider, 106 percent of the average sales price as determined by the United States
17.19 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
17.20 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
17.21 set by the commissioner. If average sales price is unavailable, the amount of payment must
17.22 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
17.23 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
17.24 The commissioner shall discount the payment rate for drugs obtained through the federal
17.25 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an
17.26 outpatient setting shall be made to the administering facility or practitioner. A retail or
17.27 specialty pharmacy dispensing a drug for administration in an outpatient setting is not
17.28 eligible for direct reimbursement.

17.29 (f) The commissioner may establish maximum allowable cost rates for specialty pharmacy
17.30 products that are lower than the ingredient cost formulas specified in paragraph (a). The
17.31 commissioner may require individuals enrolled in the health care programs administered
17.32 by the department to obtain specialty pharmacy products from providers with whom the
17.33 commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are
17.34 defined as those used by a small number of recipients or recipients with complex and chronic
17.35 diseases that require expensive and challenging drug regimens. Examples of these conditions
18.1 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C,
18.2 growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of
18.3 cancer. Specialty pharmaceutical products include injectable and infusion therapies,
18.4 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that
18.5 require complex care. The commissioner shall consult with the Formulary Committee to
18.6 develop a list of specialty pharmacy products subject to maximum allowable cost
18.7 reimbursement. In consulting with the Formulary Committee in developing this list, the
18.8 commissioner shall take into consideration the population served by specialty pharmacy
18.9 products, the current delivery system and standard of care in the state, and access to care
18.10 issues. The commissioner shall have the discretion to adjust the maximum allowable cost
18.11 to prevent access to care issues.

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

18.14 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey
18.15 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient
18.16 drugs under medical assistance. The commissioner shall ensure that the vendor has prior
18.17 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the
18.18 department to dispense outpatient prescription drugs to fee-for-service members must
18.19 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under

14.29 section 256B.064 for failure to respond. The commissioner shall require the vendor to
14.30 measure a single statewide cost of dispensing for specialty prescription drugs and a single
14.31 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies
14.32 to measure the mean, mean weighted by total prescription volume, mean weighted by
14.33 medical assistance prescription volume, median, median weighted by total prescription
14.34 volume, and median weighted by total medical assistance prescription volume. The
14.35 commissioner shall post a copy of the final cost of dispensing survey report on the
15.1 department's website. The initial survey must be completed no later than January 1, 2021,
15.2 and repeated every three years. The commissioner shall provide a summary of the results
15.3 of each cost of dispensing survey and provide recommendations for any changes to the
15.4 dispensing fee to the chairs and ranking minority members of the legislative committees
15.5 with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section
15.6 256.01, subdivision 42, this paragraph does not expire.

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

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

15.11 Sec. 6. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13k, is
15.12 amended to read:

15.13 Subd. 13k. Value-based purchasing arrangements. (a) The commissioner may enter
15.14 into a value-based purchasing arrangement under medical assistance or MinnesotaCare, by
15.15 written arrangement with a drug manufacturer based on agreed-upon metrics. The
15.16 commissioner may contract with a vendor to implement and administer the value-based
15.17 purchasing arrangement. A value-based purchasing arrangement may include but is not
15.18 limited to rebates, discounts, price reductions, risk sharing, reimbursements, guarantees,
15.19 shared savings payments, withholds, or bonuses. A value-based purchasing arrangement
15.20 must provide at least the same value or discount in the aggregate as would claiming the
15.21 mandatory federal drug rebate under the Federal Social Security Act, section 1927.

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

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

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

15.29 (e) The commissioner may provide separate reimbursement to hospitals for drugs provided
15.30 in the inpatient hospital setting as part of a value-based purchasing arrangement. This
15.31 payment must be separate from the diagnostic related group reimbursement for the inpatient
15.32 admission or discharge associated with a stay during which the patient received a drug under

18.20 section 256B.064 for failure to respond. The commissioner shall require the vendor to
18.21 measure a single statewide cost of dispensing for specialty prescription drugs and a single
18.22 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies
18.23 to measure the mean, mean weighted by total prescription volume, mean weighted by
18.24 medical assistance prescription volume, median, median weighted by total prescription
18.25 volume, and median weighted by total medical assistance prescription volume. The
18.26 commissioner shall post a copy of the final cost of dispensing survey report on the
18.27 department's website. The initial survey must be completed no later than January 1, 2021,
18.28 and repeated every three years. The commissioner shall provide a summary of the results
18.29 of each cost of dispensing survey and provide recommendations for any changes to the
18.30 dispensing fee to the chairs and ranking minority members of the legislative committees
18.31 with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section
18.32 256.01, subdivision 42, this paragraph does not expire.

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

19.1 EFFECTIVE DATE. This section is effective July 1, 2024.

15.33 this section. For payments made under this section, the hospital must not be reimbursed for
16.1 the drug under the payment methodology in section 256.969. The commissioner shall
16.2 establish the separate reimbursement rate for drugs provided under this section based on
16.3 the methodology used for drugs administered in an outpatient setting under section
16.4 256B.0625, subdivision 13e, paragraph (e).

16.5 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
16.6 of human services shall notify the revisor of statutes when federal approval is obtained.

19.2 Sec. 8. Minnesota Statutes 2022, section 256B.69, is amended by adding a subdivision to
19.3 read:

19.4 Subd. 38. **Reimbursement of network providers.** (a) A managed care plan that is a
19.5 staff model health plan company, when reimbursing network providers for services provided
19.6 to medical assistance and MinnesotaCare enrollees, must not reimburse network providers
19.7 who are employees at a higher rate than network providers who provide services under
19.8 contract for each separate service or grouping of services. This requirement does not apply
19.9 to reimbursement:

19.10 (1) of network providers when participating in value-based purchasing models that are
19.11 intended to recognize value or outcomes over volume of services, including:

19.12 (i) total cost of care and risk/gain sharing arrangements under section 256B.0755; and

19.13 (ii) other pay-for-performance arrangements or service payments, as long as the terms
19.14 and conditions of the value-based purchasing model are applied uniformly to all participating
19.15 network providers; and

19.16 (2) for services furnished by providers who are out-of-network.

19.17 (b) Any contract or agreement between a managed care plan and a network administrator,
19.18 for purposes of delivering services to medical assistance and MinnesotaCare enrollees, must
19.19 require the network administrator to comply with the requirements that apply to a managed
19.20 care plan that is a staff model health plan company under paragraph (a) when reimbursing
19.21 providers who are employees of the network administrator and providers who provide
19.22 services under contract with the network administrator. This provision applies whether or
19.23 not the managed care plan, network administrator, and providers are under the same corporate
19.24 ownership.

19.25 (c) For purposes of this subdivision, "network provider" has the meaning specified in
19.26 subdivision 37. For purposes of this subdivision, "network administrator" means any entity
19.27 that furnishes a provider network for a managed care plan company, or furnishes individual
19.28 health care providers or provider groups to a managed care plan for inclusion in the managed
19.29 care plan's provider network.

16.7 Sec. 7. CONTINGENT PROPOSAL TO FUND MEDICAL EDUCATION.

16.8 (a) If the federal Centers for Medicare and Medicaid Services deny the request by the
16.9 commissioner of human services to implement the teaching hospital surcharge under
16.10 Minnesota Statutes, section 256.9657, subdivision 2a, the commissioner of human services,
16.11 in cooperation with the commissioner of health, shall work with a third-party consultant
16.12 identified by the Health Care Workforce and Education Committee established by the
16.13 commissioner of health that has agreed to provide consulting services without charge to
16.14 Minnesota to develop a proposal to finance the nonfederal share of the medical assistance
16.15 supplemental payments described in Minnesota Statutes, section 256.969, subdivision 2g.

16.16 (b) The proposal must be designed to:

16.17 (1) enhance health care quality and the economic benefits that result from a well-trained
16.18 workforce;

16.19 (2) ensure that Minnesota has trained a sufficient number of adult and pediatric primary
16.20 and specialty care physicians by 2030;

16.21 (3) improve the cultural competence of and health care equity within the state's medical
16.22 workforce;

16.23 (4) maintain and improve the quality of academic medical centers and teaching hospitals
16.24 within the state;

16.25 (5) strengthen Minnesota's health care infrastructure; and

16.26 (6) satisfy any requirements for approval by the federal Centers for Medicare and
16.27 Medicaid Services.

16.28 (c) The commissioner of human services shall present the proposal to the chairs and
16.29 ranking minority members of the legislative committees with jurisdiction over medical
16.30 education within six months of federal denial of the request by the commissioner to
16.31 implement the teaching hospital surcharge.

17.1 Sec. 8. COUNTY-ADMINISTERED RURAL MEDICAL ASSISTANCE MODEL.

17.2 Subdivision 1. **Model development.** (a) The commissioner of human services, in
17.3 collaboration with the Association of Minnesota Counties and county-based purchasing
17.4 plans, shall develop a county-administered rural medical assistance (CARMA) model and
17.5 a detailed plan for implementing the CARMA model.

17.6 (b) The CARMA model must be designed to achieve the following objectives:

17.7 (1) provide a distinct county owned and administered alternative to the prepaid medical
17.8 assistance program;

19.30 Sec. 9. COUNTY-ADMINISTERED MEDICAL ASSISTANCE MODEL.

19.31 Subdivision 1. **Model development.** (a) The commissioner of human services, in
19.32 collaboration with the Association of Minnesota Counties and county-based purchasing
20.1 plans, shall develop a county-administered medical assistance (CAMA) model and a detailed
20.2 plan for implementing the CAMA model.

20.3 (b) The CAMA model must be designed to achieve the following objectives:

20.4 (1) provide a distinct county owned and administered alternative to the prepaid medical
20.5 assistance program;

17.9 (2) facilitate greater integration of health care and social services to address social
17.10 determinants of health in rural communities, with the degree of integration of social services
17.11 varying with each county's needs and resources;

17.12 (3) account for the smaller number of medical assistance enrollees and locally available
17.13 providers of behavioral health, oral health, specialty and tertiary care, nonemergency medical
17.14 transportation, and other health care services in rural communities; and

17.15 (4) promote greater accountability for health outcomes, health equity, customer service,
17.16 community outreach, and cost of care.

17.17 Subd. 2. **County participation.** The CARMA model must give each rural county the
17.18 option of applying to participate in the CARMA model as an alternative to participation in
17.19 the prepaid medical assistance program. The CARMA model must include a process for
17.20 the commissioner to determine whether and how a rural county can participate.

17.21 Subd. 3. **Report to the legislature.** (a) The commissioner shall report recommendations
17.22 and an implementation plan for the CARMA model to the chairs and ranking minority
17.23 members of the legislative committees with jurisdiction over health care policy and finance
17.24 by January 15, 2025. The CARMA model and implementation plan must address the issues
17.25 and consider the recommendations identified in the document titled "Recommendations
17.26 Not Contingent on Outcome(s) of Current Litigation," attached to the September 13, 2022,
17.27 e-filing to the Second Judicial District Court (Correspondence for Judicial Approval Index
17.28 #102), that relates to the final contract decisions of the commissioner of human services
17.29 regarding *South Country Health Alliance v. Minnesota Department of Human Services*, No.
17.30 62-CV-22-907 (Ramsey Cnty. Dist. Ct. 2022).

17.31 (b) The report must also identify the clarifications, approvals, and waivers that are needed
17.32 from the Centers for Medicare and Medicaid Services and include any draft legislation
17.33 necessary to implement the CARMA model.

18.1 Sec. 9. **REVISOR INSTRUCTION.**

18.2 When the proposed rule published at Federal Register, volume 88, page 25313, becomes
18.3 effective, the revisor of statutes must change: (1) the reference in Minnesota Statutes, section
18.4 256B.06, subdivision 4, paragraph (d), from Code of Federal Regulations, title 8, section

20.6 (2) facilitate greater integration of health care and social services to address social
20.7 determinants of health in rural and nonrural communities, with the degree of integration of
20.8 social services varying with each county's needs and resources;

20.9 (3) account for differences between counties in the number of medical assistance enrollees
20.10 and locally available providers of behavioral health, oral health, specialty and tertiary care,
20.11 nonemergency medical transportation, and other health care services in rural communities;
20.12 and

20.13 (4) promote greater accountability for health outcomes, health equity, customer service,
20.14 community outreach, and cost of care.

20.15 Subd. 2. **County participation.** (a) The CAMA model must give each rural and nonrural
20.16 county the option of applying to participate in the CAMA model as an alternative to
20.17 participation in the prepaid medical assistance program. The CAMA model must include a
20.18 process for the commissioner to determine whether and how a county can participate.

20.19 (b) The CAMA model may allow a county-administered managed care organization to
20.20 deliver care on a single-plan basis to all medical assistance enrollees residing in a county
20.21 if:

20.22 (1) the managed care organization contracts with all health care providers that agree to
20.23 accept the contract terms for network participation; and

20.24 (2) the commissioner determines that the health care provider network of the managed
20.25 care organization is adequate to ensure enrollee access to care and enrollee choice of
20.26 providers.

20.27 Subd. 3. **Report to the legislature.** (a) The commissioner shall report recommendations
20.28 and an implementation plan for the CAMA model to the chairs and ranking minority members
20.29 of the legislative committees with jurisdiction over health care policy and finance by January
20.30 15, 2025. The CAMA model and implementation plan must address the issues and consider
20.31 the recommendations identified in the document titled "Recommendations Not Contingent
20.32 on Outcome(s) of Current Litigation," attached to the September 13, 2022, e-filing to the
20.33 Second Judicial District Court (Correspondence for Judicial Approval Index #102), that
21.1 relates to the final contract decisions of the commissioner of human services regarding
21.2 *South Country Health Alliance v. Minnesota Department of Human Services*, No.
21.3 62-CV-22-907 (Ramsey Cnty. Dist. Ct. 2022).

21.4 (b) The report must also identify the clarifications, approvals, and waivers that are needed
21.5 from the Centers for Medicare and Medicaid Services and include any draft legislation
21.6 necessary to implement the CAMA model.

21.7 Sec. 10. **REVISOR INSTRUCTION.**

21.8 When the proposed rule published at Federal Register, volume 88, page 25313, becomes
21.9 effective, the revisor of statutes must change: (1) the reference in Minnesota Statutes, section
21.10 256B.06, subdivision 4, paragraph (d), from Code of Federal Regulations, title 8, section

Senate Language S4699-3		HHS Side-by-Side -- Art. 1		May 10, 2024 04:41 PM		House Language UES4699-2	
<u>2, section 435.4; and (2) the reference in</u>				21.11	<u>103.12, to Code of Federal Regulations, title 42, section 435.4; and (2) the reference in</u>		
<u>on 10, paragraph (a), from Code of Federal</u>				21.12	<u>Minnesota Statutes, section 256L.04, subdivision 10, paragraph (a), from Code of Federal</u>		
<u>Federal Regulations, title 45, section 155.20.</u>				21.13	<u>Regulations, title 8, section 103.12, to Code of Federal Regulations, title 45, section 155.20.</u>		
<u>ify the revisor of statutes when the proposed</u>				21.14	<u>The commissioner of human services shall notify the revisor of statutes when the proposed</u>		
<u>page 25313, becomes effective.</u>				21.15	<u>rule published at Federal Register, volume 88, page 25313, becomes effective.</u>		