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ARTICLE 1

DEPARTMENT OF HUMAN SERVICES HEALTH CARE FINANCE

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ARTICLE 1

DEPARTMENT OF HUMAN SERVICES HEALTH CARE FINANCE

Section 1. **[62V.12] STATE-FUNDED COST-SHARING REDUCTIONS.**

Subdivision 1. **Establishment.** (a) The board must develop and administer a state-funded cost-sharing reduction program for eligible persons who enroll in a silver level qualified health plan through MNsure. The board must implement the cost-sharing reduction program for plan years beginning on or after January 1, 2027.

(b) For purposes of this section, an "eligible person" is an individual who meets the eligibility criteria to receive a cost-sharing reduction under Code of Federal Regulations, title 45, section 155.305(g).

Subd. 2. **Reduction in cost-sharing.** The cost-sharing reduction program must use state money to reduce enrollee cost-sharing by increasing the actuarial value of silver level health plans for eligible persons beyond the 73 percent value established in Code of Federal Regulations, title 45, section 156.420(a)(3)(ii), to an actuarial value of 87 percent.

Subd. 3. **Administration.** The board, when administering the program, must:

(1) allow eligible persons to enroll in a silver level health plan with a state-funded cost-sharing reduction;

(2) modify the MNsure shopping tool to display the total cost-sharing reduction benefit available to individuals eligible under this section; and

(3) reimburse health carriers on a quarterly basis for the cost to the health plan providing the state-funded cost-sharing reductions.

Sec. 2. Minnesota Statutes 2023 Supplement, section 256.9631, is amended to read:

256.9631 ~~DIRECT PAYMENT SYSTEM~~ ALTERNATIVE CARE DELIVERY MODELS FOR MEDICAL ASSISTANCE AND MINNESOTACARE.

Subdivision 1. **Direction to the commissioner.** (a) The commissioner, in order to deliver services to eligible individuals, achieve better health outcomes, and reduce the cost of health care for the state, shall develop ~~an~~ implementation ~~plan~~ plans for ~~a direct payment system to deliver services to eligible individuals in order to achieve better health outcomes and reduce the cost of health care for the state. Under this system,~~ at least three care delivery models that:

(1) are alternatives to the use of commercial managed care plans to deliver health care to Minnesota health care program enrollees; and

(2) do not shift financial risk to nongovernmental entities.

(b) One of the alternative models must be a direct payment system under which eligible individuals ~~must~~ receive services through the ~~medical assistance~~ fee-for-service system,

county-based purchasing plans, ~~or~~ and county-owned health maintenance organizations. At least one additional model must include county-based purchasing plans and county-owned health maintenance organizations in their design, and must allow these entities to deliver care in geographic areas on a single plan basis, if:

(1) these entities contract with all providers that agree to contract terms for network participation; and

(2) the commissioner of human services determines that an entity's provider network is adequate to ensure enrollee access and choice.

(c) Before determining the alternative models for which implementation plans will be developed, the commissioner shall consult with the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy.

(d) The commissioner shall present ~~an~~ implementation ~~plan~~ plans for the ~~direct payment system~~ selected models to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy by January 15, 2026. The commissioner may contract for technical assistance in developing the implementation ~~plan~~ plans and conducting related studies and analyses.

~~(b) For the purposes of the direct payment system, the commissioner shall make the following assumptions:~~

~~(1) health care providers are reimbursed directly for all medical assistance covered services provided to eligible individuals, using the fee-for-service payment methods specified in chapters 256, 256B, 256R, and 256S;~~

~~(2) payments to a qualified hospital provider are equivalent to the payments that would have been received based on managed care direct payment arrangements. If necessary, a qualified hospital provider may use a county-owned health maintenance organization to receive direct payments as described in section 256B.1973; and~~

~~(3) county-based purchasing plans and county-owned health maintenance organizations must be reimbursed at the capitation rate determined under sections 256B.69 and 256B.692.~~

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Eligible individuals" means ~~qualified~~ all medical assistance ~~enrollees, defined as persons eligible for medical assistance as families and children and adults without children~~ and MinnesotaCare enrollees.

(c) "Minnesota health care programs" means the medical assistance and MinnesotaCare programs.

~~(c)~~ (d) "Qualified hospital provider" means a nonstate government teaching hospital with high medical assistance utilization and a level 1 trauma center, and all of the hospital's owned or affiliated health care professionals, ambulance services, sites, and clinics.

Subd. 3. **Implementation ~~plan~~ plans.** (a) ~~The~~ Each implementation plan must include:

(1) a timeline for the development and recommended implementation date of the ~~direct payment system~~ alternative model. In recommending a timeline, the commissioner must consider:

(i) timelines required by the existing contracts with managed care plans and county-based purchasing plans to sunset existing delivery models;

(ii) in counties that choose to operate a county-based purchasing plan under section 256B.692, timelines for any new procurements required for those counties to establish a new county-based purchasing plan or participate in an existing county-based purchasing plan;

(iii) in counties that choose to operate a county-owned health maintenance organization under section 256B.69, timelines for any new procurements required for those counties to establish a new county-owned health maintenance organization or to continue serving enrollees through an existing county-owned health maintenance organization; and

(iv) a recommendation on whether the commissioner should contract with a third-party administrator to administer the ~~direct payment system~~ alternative model, and the timeline needed for procuring an administrator;

(2) the procedures to be used to ensure continuity of care for enrollees who transition from managed care to fee-for-service and any administrative resources needed to carry out these procedures;

(3) recommended quality measures for health care service delivery;

(4) any changes to fee-for-service payment rates that the commissioner determines are necessary to ensure provider access and high-quality care and to reduce health disparities;

(5) recommendations on ensuring effective care coordination under the ~~direct payment system~~ alternative model, especially for enrollees who:

(i) are age 65 or older, blind, or have disabilities;

(ii) have complex medical conditions~~, who~~;

(iii) face socioeconomic barriers to receiving care~~, or who~~; or

(iv) are from underserved populations that experience health disparities;

(6) recommendations on ~~whether the direct payment system should provide supplemental payments~~ payment arrangements for care coordination, including:

(i) the provider types eligible for ~~supplemental~~ care coordination payments;

(ii) procedures to coordinate ~~supplemental~~ care coordination payments with existing supplemental or cost-based payment methods or to replace these existing methods; and

(iii) procedures to align care coordination initiatives funded ~~through supplemental payments~~ under ~~this section~~ the alternative model with existing care coordination initiatives;

(7) recommendations on whether the ~~direct payment system~~ alternative model should include funding to providers for outreach initiatives to patients who, because of mental illness, homelessness, or other circumstances, are unlikely to obtain needed care and treatment;

(8) recommendations for a supplemental payment to qualified hospital providers to offset any potential revenue losses resulting from the shift from managed care payments; and

~~(9) recommendations on whether and how the direct payment system should be expanded to deliver services and care coordination to medical assistance enrollees who are age 65 or older, are blind, or have a disability and to persons enrolled in MinnesotaCare; and~~

~~(10)~~ (9) recommendations for statutory changes necessary to implement the ~~direct payment system~~ alternative model.

(b) In developing ~~the~~ each implementation plan, the commissioner shall:

(1) calculate the projected cost of ~~a direct payment system~~ the alternative model relative to the cost of the current system;

(2) assess gaps in care coordination under the current medical assistance and MinnesotaCare programs;

(3) evaluate the effectiveness of approaches other states have taken to coordinate care under a fee-for-service system, including the coordination of care provided to persons who are age 65 or older, are blind, or have disabilities;

(4) estimate the loss of revenue and cost savings from other payment enhancements based on managed care plan directed payments and pass-throughs;

(5) estimate cost trends under ~~a direct payment system~~ the alternative model for managed care payments to county-based purchasing plans and county-owned health maintenance organizations;

(6) estimate the impact of ~~a direct payment system~~ the alternative model on other revenue, including taxes, surcharges, or other federally approved in lieu of services and on other arrangements allowed under managed care;

(7) consider allowing eligible individuals to opt out of managed care as an alternative approach;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Sec. 2. Minnesota Statutes 2023 Supplement, 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 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).

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Sec. 4. Minnesota Statutes 2023 Supplement, 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 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).

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(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 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.

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(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 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.

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

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

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

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

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

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

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

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

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

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

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

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

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(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) Subject to section 256.969, subdivision 2g, paragraph (i), 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).

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

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

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

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

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

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

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(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) Subject to section 256.969, subdivision 2g, paragraph (i), 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).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) total inpatient beds available, as reported on form CMS-2552-10, worksheet S-3, part 1; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) total inpatient beds available, as reported on form CMS-2552-10, worksheet S-3, part 1; and

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

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

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

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

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(f) The commissioner shall determine each eligible hospital's indirect graduate medical education supplemental payment amount by multiplying the total allowable indirect cost of graduate medical education amount calculated in paragraph (d) by:

(1) 0.95 for prospective payment system, for hospitals that are not children's hospitals and have fewer than 50 full-time equivalent trainees;

(2) 1.0 for prospective payment system, for hospitals that are not children's hospitals and have equal to or greater than 50 full-time equivalent trainees; and

(3) 1.05 for children's hospitals.

(g) An eligible hospital's annual supplemental payment under this subdivision equals the sum of the amount calculated for the eligible hospital under paragraph (e) and the amount calculated for the eligible hospital under paragraph (f).

(h) The annual supplemental payments under this subdivision are contingent upon federal approval and must conform with the requirements for permissible supplemental payments for direct and indirect graduate medical education under all applicable federal laws.

(i) An eligible hospital is only eligible for reimbursement under section 62J.692 for nonphysician graduate medical education training costs that are not accounted for in the calculation of an annual supplemental payment under this section. An eligible hospital must not accept reimbursement under section 62J.692 for physician graduate medical education training costs that are accounted for in the calculation of an annual supplemental payment under this section.

(j) For purposes of this subdivision, "children's hospital" means a Minnesota hospital designated as a children's hospital under Medicare.

(k) For purposes of this subdivision, "eligible hospital" means a hospital located in Minnesota:

(1) participating in Minnesota's medical assistance program;

(2) that has received fee-for-service medical assistance payments in the payment year; and

(3) that is either:

(i) eligible to receive graduate medical education payments from the Medicare program under Code of Federal Regulations, title 42, section 413.75; or

(ii) a children's hospital.

EFFECTIVE DATE. This section is effective January 1, 2025, or upon federal approval of this section, the amendment in this act to section 256.969, subdivision 2b, and the teaching hospital surcharge described in section 256.9657, subdivision 2a, whichever is later. The

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(f) The commissioner shall determine each eligible hospital's indirect graduate medical education supplemental payment amount by multiplying the total allowable indirect cost of graduate medical education amount calculated in paragraph (d) by:

(1) 0.95 for prospective payment system, for hospitals that are not children's hospitals and have fewer than 50 full-time equivalent trainees;

(2) 1.0 for prospective payment system, for hospitals that are not children's hospitals and have equal to or greater than 50 full-time equivalent trainees; and

(3) 1.05 for children's hospitals.

(g) An eligible hospital's annual supplemental payment under this subdivision equals the sum of the amount calculated for the eligible hospital under paragraph (e) and the amount calculated for the eligible hospital under paragraph (f).

(h) The annual supplemental payments under this subdivision are contingent upon federal approval and must conform with the requirements for permissible supplemental payments for direct and indirect graduate medical education under all applicable federal laws.

(i) An eligible hospital is only eligible for reimbursement under section 62J.692 for nonphysician graduate medical education training costs that are not accounted for in the calculation of an annual supplemental payment under this section. An eligible hospital must not accept reimbursement under section 62J.692 for physician graduate medical education training costs that are accounted for in the calculation of an annual supplemental payment under this section.

(j) For purposes of this subdivision, "children's hospital" means a Minnesota hospital designated as a children's hospital under Medicare.

(k) For purposes of this subdivision, "eligible hospital" means a hospital located in Minnesota:

(1) participating in Minnesota's medical assistance program;

(2) that has received fee-for-service medical assistance payments in the payment year; and

(3) that is either:

(i) eligible to receive graduate medical education payments from the Medicare program under Code of Federal Regulations, title 42, section 413.75; or

(ii) a children's hospital.

EFFECTIVE DATE. This section is effective the later of January 1, 2025, or federal approval of this section and sections 3 and 4. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The proposal must be designed to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 9. **REVISOR INSTRUCTION.**

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

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

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

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

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

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

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

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

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

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

Sec. 10. **REVISOR INSTRUCTION.**

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

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103.12, to Code of Federal Regulations, title 42, section 435.4; and (2) the reference in Minnesota Statutes, section 256L.04, subdivision 10, paragraph (a), from Code of Federal Regulations, title 8, section 103.12, to Code of Federal Regulations, title 45, section 155.20. The commissioner of human services shall notify the revisor of statutes when the proposed rule published at Federal Register, volume 88, page 25313, becomes effective.

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103.12, to Code of Federal Regulations, title 42, section 435.4; and (2) the reference in Minnesota Statutes, section 256L.04, subdivision 10, paragraph (a), from Code of Federal Regulations, title 8, section 103.12, to Code of Federal Regulations, title 45, section 155.20. The commissioner of human services shall notify the revisor of statutes when the proposed rule published at Federal Register, volume 88, page 25313, becomes effective.