ARTICLE 2

DEPARTMENT OF HUMAN SERVICES HEALTH CARE POLICY

Section 1. Minnesota Statutes 2022, section 62M.01, subdivision 3, is amended to read:

Subd. 3. Scope. (a) Nothing in this chapter applies to review of claims after submission
to determine eligibility for benefits under a health benefit plan. The appeal procedure
described in section 62M.06 applies to any complaint as defined under section 62Q.68,
subdivision 2, that requires a medical determination in its resolution.

(b) Effective January 1, 2026, this chapter does not apply to managed care plans
or county-based purchasing plans when the plan is providing coverage to state public health
care program enrollees under chapter 256B or 256L.

(c) Effective January 1, 2026, the following sections of this chapter apply to services
delivered through fee-for-service under chapters 256B and 256L: sections 62M.02,
subdivisions 1 to 5, 7 to 12, 13, 14 to 18, and 21; 62M.04; 62M.05; subdivisions 1 to 4;
62M.06; subdivisions 1 to 3; 62M.07; 62M.072; 62M.09; 62M.10; 62M.12; and 62M.17.

Sec. 2. Minnesota Statutes 2023 Supplement, section 256.0471, subdivision 1, as amended
by Laws 2024, chapter 80, article 1, section 76, is amended to read:

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

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

Sec. 3. Minnesota Statutes 2022, section 256.9657, subdivision 8, is amended to read:

Subd. 8. Commissioner’s duties. (a) Beginning October 1, 2023, the commissioner of
human services shall annually report to the chairs and ranking minority members of the
legislative committees with jurisdiction over health care policy and finance regarding the
provider surcharge program. The report shall include information on total billings, total

ARTICLE 2

DEPARTMENT OF HUMAN SERVICES HEALTH CARE POLICY

THE FOLLOWING LANGUAGE IS FROM HOUSE ARTICLE 4, SECTION 16.

Sec. 16. Minnesota Statutes 2022, section 62M.01, subdivision 3, is amended to read:

Subd. 3. Scope. (a) Nothing in this chapter applies to review of claims after submission
to determine eligibility for benefits under a health benefit plan. The appeal procedure
described in section 62M.06 applies to any complaint as defined under section 62Q.68,
subdivision 2, that requires a medical determination in its resolution.

(b) Effective January 1, 2026, this chapter does not apply to managed care plans
or county-based purchasing plans when the plan is providing coverage to state public health
care program enrollees under chapter 256B or 256L.

(c) Effective January 1, 2026, the following sections of this chapter apply to services
delivered through fee-for-service under chapters 256B and 256L: sections 62M.02,
subdivisions 1 to 5, 7 to 12, 13, 14 to 18, and 21; 62M.04; 62M.05; subdivisions 1 to 4;
62M.06; subdivisions 1 to 3; 62M.07; 62M.072; 62M.09; 62M.10; 62M.12; and 62M.17.

The commissioner shall comply with the requirements of section 62M.18 using existing
appropriations.

Sec. 2. Minnesota Statutes 2023 Supplement, section 256.0471, subdivision 1, as amended
by Laws 2024, chapter 80, article 1, section 76, is amended to read:

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

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

Sec. 2. Minnesota Statutes 2022, section 256.9657, subdivision 8, is amended to read:

Subd. 8. Commissioner’s duties. (a) Beginning October 1, 2023, the commissioner of
human services shall annually report to the chairs and ranking minority members of the
legislative committees with jurisdiction over health care policy and finance regarding the
provider surcharge program. The report shall include information on total billings, total
collections, and administrative expenditures for the previous fiscal year. This paragraph expires January 1, 2032.

(a) The surcharge shall be adjusted by inflationary and caseload changes in future bienniums to maintain reimbursement of health care providers in accordance with the requirements of the state and federal laws governing the medical assistance program, including the requirements of the Medicaid moratorium amendments of 1991 found in Public Law No. 102-234.

(b) The commissioner shall request the Minnesota congressional delegation to support a change in federal law that would prohibit federal disallowances for any state that makes a good faith effort to comply with Public Law 102-234 by enacting conforming legislation prior to the issuance of federal implementing regulations.

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

Subd. 2h. Alternate inpatient payment rate for a discharge. (a) Effective retroactively from January 1, 2024, in any rate year in which a children's hospital discharge is included in the federally required disproportionate share hospital payment audit where the patient discharged had resided in a children's hospital for over 20 years, the commissioner shall compute an alternate inpatient rate for the children's hospital. The alternate payment rate must be the rate computed under this section excluding the disproportionate share hospital payment under subdivision 9, paragraph (d), clause (1), increased by an amount equal to 99 percent of what the disproportionate share hospital payment would have been under subdivision 9, paragraph (d), clause (1), had the discharge been excluded.

(b) In any rate year in which payment to a children's hospital is made using this alternate payment rate, payments must not be made to the hospital under subdivisions 2e, 2f, and 9.

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.

Sec. 5. Minnesota Statutes 2022, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. Income and assets generally. (a)(1) Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the Supplemental Security Income program shall be used, except as provided under in clause (2) and subdivision 3, paragraph (a), clause (6).

(2) State tax credits, rebates, and refunds must not be counted as income. State tax credits, rebates, and refunds must not be counted as assets for a period of 12 months after the month of receipt.

Subd. 2h. Alternate inpatient payment rate for a discharge. (a) Effective retroactively from January 1, 2024, in any rate year in which a children's hospital discharge is included in the federally required disproportionate share hospital payment audit where the patient discharged had resided in a children's hospital for over 20 years, the commissioner shall compute an alternate inpatient rate for the children's hospital. The alternate payment rate must be the rate computed under this section excluding the disproportionate share hospital payment under subdivision 9, paragraph (d), clause (1), increased by an amount equal to 99 percent of what the disproportionate share hospital payment would have been under subdivision 9, paragraph (d), clause (1), had the discharge been excluded.

(b) In any rate year in which payment to a children's hospital is made using this alternate payment rate, payments must not be made to the hospital under subdivisions 2e, 2f, and 9.

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.

Subd. 1a. Income and assets generally. (a)(1) Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the Supplemental Security Income program shall be used, except as provided under in clause (2) and subdivision 3, paragraph (a), clause (6).

(2) State tax credits, rebates, and refunds must not be counted as income. State tax credits, rebates, and refunds must not be counted as assets for a period of 12 months after the month of receipt.
community-based waiver services whose eligibility for medical assistance is determined
without regard to parental income, child support payments, including any payments made
by an obligor in satisfaction of or in addition to a temporary or permanent order for child
support, and Social Security payments are not counted as income. 

For these purposes, a "methodology" does not include an asset or income standard, or
accounting method, or method of determining effective dates.

For individuals whose income eligibility is determined using the modified adjusted
gross income methodology in clause (1):

(i) the commissioner shall subtract from the individual's modified adjusted gross income
an amount equivalent to five percent of the federal poverty guidelines; and

(ii) the individual's current monthly income and household size is used to determine
eligibility for the 12-month eligibility period. If an individual's income is expected to vary
month to month, eligibility is determined based on the income predicted for the 12-month
eligibility period.

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

Sec. 6. Minnesota Statutes 2022, section 256B.056, subdivision 10, is amended to read:

Subd. 10. Eligibility verification. (a) The commissioner shall require women who are
applying for the continuation of medical assistance coverage following the end of the
12-month postpartum period to update their income and asset information and to submit
any required income or asset verification.

(b) The commissioner shall determine the eligibility of private-sector health care coverage
for infants less than one year of age eligible under section 256B.055, subdivision 10, or

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

Sec. 4. Minnesota Statutes 2022, section 256B.056, subdivision 10, is amended to read:

Subd. 10. Eligibility verification. (a) The commissioner shall require women who are
applying for the continuation of medical assistance coverage following the end of the
12-month postpartum period to update their income and asset information and to submit
any required income or asset verification.

(b) The commissioner shall determine the eligibility of private-sector health care coverage
for infants less than one year of age eligible under section 256B.055, subdivision 10, or
(c) The commissioner shall verify assets and income for all applicants, and for all recipients upon renewal.

(d) The commissioner shall utilize information obtained through the electronic service established by the secretary of the United States Department of Health and Human Services and other available electronic data sources in Code of Federal Regulations, title 42, sections 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish standards to define when information obtained electronically is reasonably compatible with information provided by applicants and enrollees, including use of self-attestation, to accomplish real-time eligibility determinations and maintain program integrity.

(e) Each person applying for or receiving medical assistance under section 256B.055, subdivision 7, and any other person whose resources are required by law to be disclosed to determine the applicant's or recipient's eligibility must authorize the commissioner to obtain information from financial institutions to verify unreported accounts. For purposes of this paragraph, an authorization to verify assets meets the requirements of the Right to Financial Privacy Act, United States Code, title 2, chapter 35, and need not be furnished to the financial institution.

(f) County and tribal agencies shall comply with the standards established by the commissioner for appropriate use of the asset verification system specified in section 256.01, subdivision 18f.

Sec. 7. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 8, is amended to read:

Sec. 7. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 8, is amended to read:

Subd. 8. Medical assistance payment for assertive community treatment and intensive residential treatment services. (a) Payment for intensive residential treatment services and assertive community treatment in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

(b) Except as indicated in paragraph (c), payment will not be made to more than one entity for each client for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.
(c) The commissioner shall determine one rate for each provider that will bill medical assistance for residential services under this section and one rate for each assertive community treatment provider. If a single entity provides both services, one rate is established for the entity’s residential services and another rate for the entity's nonresidential services under this section. A provider is not eligible for payment under this section without authorization from the commissioner. The commissioner shall develop rates using the following criteria:

(i) the provider's cost for services shall include direct services costs, other program costs, and other costs determined as follows:

(a) the direct services costs must be determined using actual costs of salaries, benefits, payroll taxes, and training of direct service staff and service-related transportation;

(b) other program costs not included in item (i) must be determined as a specified percentage of the direct services costs as determined by item (i). The percentage used shall be determined by the commissioner based upon the average of percentages that represent the relationship of other program costs to direct services costs among the entities that provide similar services;

(c) physical plant costs calculated based on the percentage of space within the program that is entirely devoted to treatment and programming. This does not include administrative or residential space;

(d) assertive community treatment physical plant costs must be reimbursed as part of the costs described in item (ii); and

(e) subject to federal approval, up to an additional five percent of the total rate may be added to the program rate as a quality incentive based upon the entity meeting performance criteria specified by the commissioner;

(2) actual cost is defined as costs which are allowable, allocable, and reasonable, and consistent with federal reimbursement requirements under Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and Budget Circular Number A-122, relating to nonprofit entities;

(3) the number of service units;

(4) the degree to which clients will receive services other than services under this section; and

(5) the costs of other services that will be separately reimbursed.

(d) The rate for intensive residential treatment services and assertive community treatment must exclude the medical assistance room and board rate, as defined in section 256B.056, subdivision 5d, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.
Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist, or other health care professional providing physician services within their scope of practice, is a member of the intensive residential treatment services team. Physician services, whether billed separately or included in the rate, may be delivered by telehealth. For purposes of this paragraph, “telehealth” has the meaning given to “mental health telehealth” in section 256B.0625, subdivision 46, when telehealth is used to provide intensive residential treatment services.

When services under this section are provided by an assertive community treatment provider, case management functions must be an integral part of the team.

The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

The rates for existing programs must be established prospectively based upon the expenditures and utilization over a prior 12-month period using the criteria established in paragraph (c). The rates for new programs must be established based upon estimated expenditures and estimated utilization using the criteria established in paragraph (c). Effective for the rate years beginning on and after January 1, 2024, rates for assertive community treatment, adult residential crisis stabilization services, and intensive residential treatment services must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the fourth quarter of the calendar year before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

Entities who discontinue providing services must be subject to a settle-up process whereby actual costs and reimbursement for the previous 12 months are compared. In the event that the entity was paid more than the entity's actual costs plus any applicable performance-related funding due the provider, the excess payment must be reimbursed to the department. If a provider's revenue is less than actual allowed costs due to lower utilization than projected, the commissioner may reimburse the provider to recover its actual allowable costs. The resulting adjustments by the commissioner must be proportional to the percent of total units of service reimbursed by the commissioner and must reflect a difference of greater than five percent.

A provider may request of the commissioner a review of any rate-setting decision made under this subdivision.
(1) posterior fillings are paid at the amalgam rate;
(2) application of sealants are covered once every five years per permanent molar; and
(3) application of fluoride varnish is covered once every six months.

(c) In addition to the services specified in paragraph (a), medical assistance covers
the following services:
(1) house calls or extended care facility calls for on-site delivery of covered services;
(2) behavioral management when additional staff time is required to accommodate
behavioral challenges and sedation is not used;
(3) oral or IV sedation, if the covered dental service cannot be performed safely without
it or would otherwise require the service to be performed under general anesthesia in a
hospital or surgical center; and
(4) prophylaxis, in accordance with an appropriate individualized treatment plan, but
no more than four times per year.

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

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

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

Subd. 12. Eyeglasses, dentures, and prosthetic and orthotic devices. (a) Medical
assistance covers eyeglasses, dentures, and prosthetic and orthotic devices if prescribed by
a licensed practitioner.

(b) For purposes of prescribing prosthetic and orthotic devices, "licensed practitioner"
includes a physician, an advanced practice registered nurse, a physician assistant, or a
podiatrist.

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

Sec. 10. 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, unless the prescription savings club or prescription discount club is one
in which an individual pays a recurring monthly access fee for unlimited access to a defined
list of drugs for which the pharmacy does not bill the member or a payer on a
per-standard-transaction basis. The amount of payment basis must be reduced to reflect all
discount amounts applied to the charge by any third-party provider/insurer agreement or
contract for submitted charges to medical assistance programs. The net submitted charge
may not be greater than the patient liability for the service. The professional dispensing fee
shall be $10.77 for prescriptions filled with legend drugs meeting the definition of "covered
outpatient drugs" according to United States Code, title 42, section 1396m-8(k)(2). The
dispensing fee for intravenous solutions that must be compounded by the pharmacist shall
be $10.77 per claim. The professional dispensing fee for prescriptions filled with
over-the-counter drugs meeting the definition of covered outpatient drugs shall be $10.77
for dispensed quantities equal to or greater than the number of units contained in the
manufacturer's original package. The professional dispensing fee shall be prorated based
on the percentage of the package dispensed when the pharmacy dispenses a quantity less
than the number of units contained in the manufacturer's original package. The pharmacy
dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered
outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units
contained in the manufacturer's original package and shall be prorated based on the
percentage of the package dispensed when the pharmacy dispenses a quantity less than the
number of units contained in the manufacturer's original package: The National Average
Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug.
For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient
cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for
a provider participating in the federal 340B Drug Pricing Program shall be either the 340B
Drug Pricing Program ceiling price established by the Health Resources and Services
Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as
the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in
the United States, not including prompt pay or other discounts, rebates, or reductions in
price, for the most recent month for which information is available, as reported in wholesale
price guides or other publications of drug or biological pricing data. The maximum allowable
cost of a multisource drug may be set by the commissioner and it shall be comparable to
the actual acquisition cost of the drug product and no higher than the NADAC of the generic
product. Establishment of the amount of payment for drugs shall not be subject to the
requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
an automated drug distribution system meeting the requirements of section 151.58, or a
packaging system meeting the packaging standards set forth in Minnesota Rules, part
6000.2700, 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.
27.9 (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.
27.10 (d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC of the generic product or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.
27.11 (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.
27.12 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.
27.13 (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 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.

THE FOLLOWING LANGUAGE IS FROM HOUSE ARTICLE 4, SECTION 60.

Sec. 60. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 25c. Applicability of utilization review provisions. Effective January 1, 2026, the following provisions of chapter 62M apply to the commissioner when delivering services through fee-for-service under chapters 256B and 256L: sections 62M.02, subdivisions 1 to 5, 7 to 12, 13, 14 to 18, and 21; 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions 1 to 3; 62M.07; 62M.09; 62M.10; 62M.12; and 62M.17, subdivision 2.

Sec. 12. Minnesota Statutes 2023 Supplement, section 256B.0701, subdivision 6, is amended to read:

Subd. 6. Recuperative care facility rate. (a) The recuperative care facility rate is for facility costs and must be paid from state money in an amount equal to the medical assistance non-mandated MSA equivalent rate as defined in section 256L.03, subdivision 11a, at the time the recuperative care services were provided. The eligibility standards in chapter 256I...
do not apply to the recuperative care facility rate. The recuperative care facility rate is only
paid when the recuperative care services rate is paid to a provider. Providers may opt to
only receive the recuperative care services rate.

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

Sec. 6. Minnesota Statutes 2022, section 256B.0757, subdivision 4a, is amended to read:

Subd. 4a. Behavioral health home services provider requirements. A behavioral
health home services provider must:

(1) be an enrolled Minnesota Health Care Programs provider;
(2) provide a medical assistance covered primary care or behavioral health service;
(3) utilize an electronic health record;
(4) utilize an electronic patient registry that contains data elements required by the
commissioner;
(5) demonstrate the organization's capacity to administer screenings approved by the
commissioner for substance use disorder or alcohol and tobacco use;
(6) demonstrate the organization's capacity to refer an individual to resources appropriate
to the individual's screening results;
(7) have policies and procedures to track referrals to ensure that the referral met the
individual's needs;
(8) conduct a brief needs assessment when an individual begins receiving behavioral
health home services. The brief needs assessment must be completed with input from the
individual and the individual's identified supports. The brief needs assessment must address
the individual's immediate safety and transportation needs and potential barriers to
participating in behavioral health home services;
(9) conduct a health wellness assessment within 60 days after intake that contains all
required elements identified by the commissioner;
(10) conduct a health action plan that contains all required elements identified by the
commissioner. The plan must be completed within 90 days after intake and must be updated
at least once every six months, or more frequently if significant changes to an individual's
needs or goals occur;
(11) agree to cooperate with and participate in the state's monitoring and evaluation of
behavioral health home services; and
(12) obtain the individual's written consent to begin receiving behavioral health home
services using a form approved by the commissioner.
EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 7. Minnesota Statutes 2022, section 256B.0757, subdivision 4d, is amended to read:

Subd. 4d. Behavioral health home services delivery standards. (a) A behavioral health home services provider must meet the following service delivery standards:

(1) establish and maintain processes to support the coordination of an individual's primary care, behavioral health, and dental care;

(2) maintain a team-based model of care, including regular coordination and communication between behavioral health home services team members;

(3) use evidence-based practices that recognize and are tailored to the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting the individual's health and health care choices;

(4) use person-centered planning practices to ensure the individual's health action plan accurately reflects the individual's preferences, goals, resources, and optimal outcomes for the individual and the individual's identified supports;

(5) use the patient registry to identify individuals and population subgroups requiring specific levels or types of care and provide or refer the individual to needed treatment, intervention, or services;

(6) utilize the Department of Human Services Partner Portal to identify past and current treatment or services and identify potential gaps in care using a tool approved by the commissioner;

(7) deliver services consistent with the standards for frequency and face-to-face contact required by the commissioner;

(8) ensure that a diagnostic assessment is completed for each individual receiving behavioral health home services within six months of the start of behavioral health home services;

(9) deliver services in locations and settings that meet the needs of the individual;

(10) provide a central point of contact to ensure that individuals and the individual's identified supports can successfully navigate the array of services that impact the individual's health and well-being;

(11) have capacity to assess an individual's readiness for change and the individual's capacity to integrate new health care or community supports into the individual's life;

(12) offer or facilitate the provision of wellness and prevention education on evidenced-based curriculums specific to the prevention and management of common chronic conditions;
(13) help an individual set up and prepare for medical, behavioral health, social service, or community support appointments, including accompanying the individual to appointments as appropriate, and providing follow-up with the individual after these appointments;

(14) offer or facilitate the provision of health coaching related to chronic disease management and how to navigate complex systems of care to the individual, the individual's family, and identified supports;

(15) connect an individual, the individual's family, and identified supports to appropriate support services that help the individual overcome access or service barriers, increase self-sufficiency skills; and improve overall health;

(16) provide effective referrals and timely access to services; and

(17) establish a continuous quality improvement process for providing behavioral health home services.

(b) The behavioral health home services provider must also create a plan, in partnership with the individual and the individual's identified supports, to support the individual after discharge from a hospital, residential treatment program, or other setting. The plan must include protocols for:

(1) maintaining contact between the behavioral health home services team member, the individual, and the individual's identified supports during and after discharge;

(2) linking the individual to new resources as needed;

(3) reestablishing the individual's existing services and community and social supports; and

(4) following up with appropriate entities to transfer or obtain the individual's service records as necessary for continued care.

(c) If the individual is enrolled in a managed care plan, a behavioral health home services provider must:

(1) notify the behavioral health home services contact designated by the managed care plan within 30 days of when the individual begins behavioral health home services; and

(2) adhere to the managed care plan communication and coordination requirements described in the behavioral health home services manual.

(d) Before terminating behavioral health home services, the behavioral health home services provider must:

(1) provide a 60-day notice of termination of behavioral health home services to all individuals receiving behavioral health home services; the commissioner, and managed care plans, if applicable; and
Subd. 7. Medical assistance payment and rate setting. (a) Payment for services in this 
section must be based on one daily encounter rate per provider inclusive of the following 
services received by an eligible client in a given calendar day: all rehabilitative services, 
supports, and ancillary activities under this section, staff travel time to provide rehabilitative 
services under this section, and crisis response services under section 256B.0624. 
(b) Payment must not be made to more than one entity for each client for services 
provided under this section on a given day. If services under this section are provided by a 
team that includes staff from more than one entity, the team shall determine how to distribute 
the payment among the members. 
(c) The commissioner shall establish regional cost-based rates for entities that will bill 
medical assistance for nonresidential intensive rehabilitative mental health services. In 
developing these rates, the commissioner shall consider: 
(1) the cost for similar services in the health care trade area; 
(2) actual costs incurred by entities providing the services; 
(3) the intensity and frequency of services to be provided to each client; 
(4) the degree to which clients will receive services other than services under this section; 
and 
(5) the costs of other services that will be separately reimbursed. 
(d) The rate for a provider must not exceed the rate charged by that provider for the 
same service to other payers. 
(e) Effective for the rate years beginning on and after January 1, 2024, rates must be 
annually adjusted for inflation using the Centers for Medicare and Medicaid Services 
Medicare Economic Index, as forecasted in the fiscal third quarter of the calendar year 
before the rate year. The inflation adjustment must be based on the 12-month period from 
the midpoint of the previous rate year to the midpoint of the rate year for which the rate is 
being determined.
Sec. 8. Minnesota Statutes 2023 Supplement, section 256B.764, is amended to read:

(a) Effective for services rendered on or after July 1, 2007, payment rates for family planning services shall be increased by 25 percent over the rates in effect June 30, 2007, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1.

(b) Effective for services rendered on or after July 1, 2013, payment rates for family planning services shall be increased by 20 percent over the rates in effect June 30, 2013, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1. The commissioner shall adjust capitation rates to managed care and county-based purchasing plans to reflect this increase, and shall require plans to pass on the full amount of the rate increase to eligible community clinics, in the form of higher payment rates for family planning services.

(c) Effective for services provided on or after January 1, 2024, payment rates for family planning, when such services are provided by an eligible community clinic as defined in section 145.9268, subdivision 1, and abortion services shall be increased by 20 percent.

This increase does not apply to federally qualified health centers, rural health centers, or Indian health services.

Sec. 15. Minnesota Statutes 2023 Supplement, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. Covered health services. (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of special education services, home care nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, community first services and supports under section 256B.85, behavioral health home services under section 256B.0757, housing stabilization services under section 256B.051, and nursing home or intermediate care facilities services.

(b) Covered health services shall be expanded as provided in this section.

(c) For the purposes of covered health services under this section, "child" means an individual younger than 19 years of age.

Sec. 16. Minnesota Statutes 2022, section 524.3-801, as amended by Laws 2024, chapter 79, article 9, section 20, is amended to read:

524.3-801 NOTICE TO CREDITORS.

(a) Unless notice has already been given under this section, upon appointment of a general personal representative in informal proceedings or upon the filing of a petition for formal appointment of a general personal representative, notice thereof, in the form prescribed

Sec. 14. Minnesota Statutes 2023 Supplement, section 256B.764, is amended to read:

256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.

(a) Effective for services rendered on or after July 1, 2007, payment rates for family planning services shall be increased by 25 percent over the rates in effect June 30, 2007, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1.

(b) Effective for services rendered on or after July 1, 2013, payment rates for family planning services shall be increased by 20 percent over the rates in effect June 30, 2013, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1. The commissioner shall adjust capitation rates to managed care and county-based purchasing plans to reflect this increase, and shall require plans to pass on the full amount of the rate increase to eligible community clinics, in the form of higher payment rates for family planning services.

(c) Effective for services provided on or after January 1, 2024, payment rates for family planning, when such services are provided by an eligible community clinic as defined in section 145.9268, subdivision 1, and abortion services shall be increased by 20 percent.

This increase does not apply to federally qualified health centers, rural health centers, or Indian health services.

Sec. 9. Minnesota Statutes 2023 Supplement, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. Covered health services. (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of special education services, home care nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, community first services and supports under section 256B.85, behavioral health home services under section 256B.0757, housing stabilization services under section 256B.051, and nursing home or intermediate care facilities services.

(b) Covered health services shall be expanded as provided in this section.

(c) For the purposes of covered health services under this section, "child" means an individual younger than 19 years of age.

Sec. 10. Minnesota Statutes 2022, section 524.3-801, as amended by Laws 2024, chapter 79, article 9, section 20, is amended to read:

524.3-801 NOTICE TO CREDITORS.

(a) Unless notice has already been given under this section, upon appointment of a general personal representative in informal proceedings or upon the filing of a petition for formal appointment of a general personal representative, notice thereof, in the form prescribed
by court rule, shall be given under the direction of the court administrator by publication.

(2) The personal representative shall, within three months after the date of the first publication of the notice, serve a copy of the notice upon each then known and identified creditor in the manner provided in paragraph (c). If the decedent or a predeceased spouse of the decedent received assistance for which a claim could be filed under section 246.53, 256B.15, 256D.16, or 261.04, notice to the commissioner of human services or direct care and treatment executive board, as applicable, must be given under paragraph (d) instead of under this paragraph or paragraph (c). A creditor is "known" if: (i) the personal representative knows that the creditor has asserted a claim that arose during the decedent's life against the decedent or the decedent's estate; (ii) the creditor has asserted a claim that arose during the decedent's life and the fact is clearly disclosed in accessible financial records known and available to the personal representative; or (iii) the claim of the creditor would be revealed by a reasonably diligent search for creditors of the decedent in accessible financial records known and available to the personal representative. Under this section, a creditor is "identified" if the personal representative's knowledge of the name and address of the creditor will permit service of notice to be made under paragraph (c).

(3) Unless the claim has already been presented to the personal representative or paid, the personal representative shall serve a copy of the notice required by paragraph (b) upon each creditor of the decedent who is then known to the personal representative and identified either by delivery of a copy of the required notice to the creditor, or by mailing a copy of the notice to the creditor by certified, registered, or ordinary first class mail addressed to the creditor at the creditor's office or place of residence.

(4) (1) Effective for decedents dying on or after July 1, 1997, if the decedent or a predeceased spouse of the decedent received assistance for which a claim could be filed under section 246.53, 256B.15, 256D.16, or 261.04, the personal representative or the attorney for the personal representative shall serve the commissioner or executive board, as applicable, with notice in the manner prescribed in paragraph (c), or electronically in a manner prescribed by the commissioner or executive board, as soon as practicable after the appointment of the personal representative. The notice must state the decedent's full name, date of birth, and Social Security number and, to the extent then known after making a reasonably diligent inquiry, the full name, date of birth, and Social Security number for each of the decedent's predeceased spouses. The notice may also contain a statement that, after making a reasonably diligent inquiry, the personal representative has determined that the decedent did not have any predeceased spouses or that the personal representative has been unable to determine one or more of the previous items of information for a predeceased spouse of the decedent. A copy of the notice to creditors must be attached to and be a part of the notice to the commissioner or executive board.
(2) Notwithstanding a will or other instrument or law to the contrary, except as allowed
in this paragraph, no property subject to administration by the estate may be distributed by
the estate or the personal representative until 70 days after the date the notice is served on
the commissioner or executive board as provided in paragraph (c), unless the local agency
consents as provided for in clause (6). This restriction on distribution does not apply to the
personal representative's sale of real or personal property, but does apply to the net proceeds
the estate receives from these sales. The personal representative, or any person with personal
knowledge of the facts, may provide an affidavit containing the description of any real or
personal property affected by this paragraph and stating facts showing compliance with this
paragraph. If the affidavit describes real property, it may be filed or recorded in the office
of the county recorder or registrar of titles for the county where the real property is located.

This paragraph does not apply to proceedings under sections 524.3-1203 and 525.31, or
when a duly authorized agent of a county is acting as the personal representative of the
estate.

(3) At any time before an order or decree is entered under section 524.3-1001 or
524.3-1002, or a closing statement is filed under section 524.3-1003, the personal
representative or the attorney for the personal representative may serve an amended notice
on the commissioner or executive board to add variations or other names of the decedent
or a predeceased spouse named in the notice, in the name of a predeceased spouse omitted
from the notice, to add or correct the date of birth or Social Security number of a decedent
or predeceased spouse named in the notice, or to correct any other deficiency in a prior
notice. The amended notice must state the decedent's name, date of birth, and Social Security
number, the case name, case number, and district court in which the estate is pending, and
the date the notice being amended was served on the commissioner or executive board. If
the amendment adds the name of a predeceased spouse omitted from the notice, it must also
state that spouse's full name, date of birth, and Social Security number. The amended notice
must be served on the commissioner or executive board in the same manner as the original
notice. Upon service, the amended notice relates back to and is effective from the date the
notice it amends was served, and the time for filing claims arising under section 246.53,
256B.15, 256D.16 or 261.04 is extended by 60 days from the date of service of the amended
notice. Claims filed during the 60-day period are undischarged and unbarred claims, may
be prosecuted by the entities entitled to file those claims in accordance with section
524.3-1004, and the limitations in section 524.3-1006 do not apply. The personal
representative or any person with personal knowledge of the facts may provide and file or
record an affidavit in the same manner as provided for in clause (1).

(4) Within one year after the date an order or decree is entered under section 524.3-1001
or 524.3-1002 or a closing statement is filed under section 524.3-1003, any person who has
an interest in property that was subject to administration by the estate may serve an amended
notice on the commissioner or executive board to add variations or other names of the
decedent or a predeceased spouse named in the notice, the name of a predeceased spouse
omitted from the notice, to add or correct the date of birth or Social Security number of a
decedent or predeceased spouse named in the notice, or to correct any other deficiency in
a prior notice. The amended notice must be served on the commissioner or executive board in the same manner as the original notice and must contain the information required for amendments under clause (3). If the amendment adds the name of a predeceased spouse omitted from the notice, it must also state that spouse's full name, date of birth, and Social Security number. Upon service, the amended notice relates back to and is effective from the date the notice it amends was served. If the amended notice adds the name of an omitted predeceased spouse or adds or corrects the Social Security number or date of birth of the decedent or a predeceased spouse already named in the notice, then, notwithstanding any other laws to the contrary, claims against the decedent's estate on account of those persons resulting from the amendment and arising under section 246.53, 256B.15, 256D.16, or 261.04 are undischargeable and unbarred, claims may be prosecuted by the entities entitled to file those claims in accordance with section 524.3-1004, and the limitations in section 524.3-1006 do not apply. The person filing the amendment or any other person with personal knowledge of the facts may provide file or record an affidavit describing affected real or personal property in the same manner as clause (1).

(5) After one year from the date an order or decree is entered under section 524.3-1001 or 524.3-1002, or a closing statement is filed under section 524.3-1003, no error, omission, or defect of any kind in the notice to the commissioner or executive board required under this paragraph or in the process of service of the notice on the commissioner or executive board, or the failure to serve the commissioner or executive board with notice as required by this paragraph, makes any distribution of property by a personal representative void or voidable. The distributee's title to the distributed property shall be free of any claims based upon a failure to comply with this paragraph.

(6) The local agency may consent to a personal representative's request to distribute property subject to administration by the estate to distributees during the 70-day period after service of notice on the commissioner or executive board. The local agency may grant or deny the request in whole or in part and may attach conditions to its consent as it deems appropriate. When the local agency consents to a distribution, it shall give the estate a written certificate evidencing its consent to the early distribution of assets at no cost. The certificate must include the name, case number, and district court in which the estate is pending, the name of the local agency, describe the specific real or personal property to which the consent applies, state that the local agency consents to the distribution of the specific property described in the consent during the 70-day period following service of the notice on the commissioner or executive board, that the consent is unconditional or list all of the terms and conditions of the consent, be dated, and may include other contents as may be appropriate. The certificate must be signed by the director of the local agency or the director's designees and is effective as of the date it is dated unless it provides otherwise. The signature of the director or the director's designee does not require any acknowledgment. The certificate shall be prima facie evidence of the facts it states, may be attached to or combined with a deed or any other instrument of conveyance and, when so attached or combined, shall constitute a single instrument. If the certificate describes real property, it shall be accepted for recording or filing by the county recorder or registrar of titles in the county in which the

a prior notice. The amended notice must be served on the commissioner or executive board in the same manner as the original notice and must contain the information required for amendments under clause (3). If the amendment adds the name of a predeceased spouse omitted from the notice, it must also state that spouse's full name, date of birth, and Social Security number. Upon service, the amended notice relates back to and is effective from the date the notice it amends was served. If the amended notice adds the name of an omitted predeceased spouse or adds or corrects the Social Security number or date of birth of the decedent or a predeceased spouse already named in the notice, then, notwithstanding any other laws to the contrary, claims against the decedent's estate on account of those persons resulting from the amendment and arising under section 246.53, 256B.15, 256D.16, or 261.04 are undischargeable and unbarred, claims may be prosecuted by the entities entitled to file those claims in accordance with section 524.3-1004, and the limitations in section 524.3-1006 do not apply. The person filing the amendment or any other person with personal knowledge of the facts may provide file or record an affidavit describing affected real or personal property in the same manner as clause (1).

(5) After one year from the date an order or decree is entered under section 524.3-1001 or 524.3-1002, or a closing statement is filed under section 524.3-1003, no error, omission, or defect of any kind in the notice to the commissioner or executive board required under this paragraph or in the process of service of the notice on the commissioner or executive board, or the failure to serve the commissioner or executive board with notice as required by this paragraph, makes any distribution of property by a personal representative void or voidable. The distributee's title to the distributed property shall be free of any claims based upon a failure to comply with this paragraph.

(6) The local agency may consent to a personal representative's request to distribute property subject to administration by the estate to distributees during the 70-day period after service of notice on the commissioner or executive board. The local agency may grant or deny the request in whole or in part and may attach conditions to its consent as it deems appropriate. When the local agency consents to a distribution, it shall give the estate a written certificate evidencing its consent to the early distribution of assets at no cost. The certificate must include the name, case number, and district court in which the estate is pending, the name of the local agency, describe the specific real or personal property to which the consent applies, state that the local agency consents to the distribution of the specific property described in the consent during the 70-day period following service of the notice on the commissioner or executive board, that the consent is unconditional or list all of the terms and conditions of the consent, be dated, and may include other contents as may be appropriate. The certificate must be signed by the director of the local agency or the director's designees and is effective as of the date it is dated unless it provides otherwise. The signature of the director or the director's designee does not require any acknowledgment. The certificate shall be prima facie evidence of the facts it states, may be attached to or combined with a deed or any other instrument of conveyance and, when so attached or combined, shall constitute a single instrument. If the certificate describes real property, it shall be accepted for recording or filing by the county recorder or registrar of titles in the county in which the
property is located. If the certificate describes real property and is not attached to or combined
with a deed or other instrument of conveyance, it shall be accepted for recording or filing
by the county recorder or registrar of titles in the county in which the property is located.
The certificate constitutes a waiver of the 70-day period provided for in clause (2) with
respect to the property it describes and is prima facie evidence of service of notice on the
commissioner or executive board. The certificate is not a waiver or relinquishment of any
claims arising under section 246.53, 256B.15, 256D.16, or 261.04, and does not otherwise
constitute a waiver of any of the personal representative's duties under this paragraph.
Distributees who receive property pursuant to a consent to an early distribution shall remain
liable to creditors of the estate as provided for by law.

(7) All affidavits provided for under this paragraph:
(i) shall be provided by persons who have personal knowledge of the facts stated in the
affidavit;
(ii) may be filed or recorded in the office of the county recorder or registrar of titles in
the county in which the real property they describe is located for the purpose of establishing
compliance with the requirements of this paragraph; and
(iii) are prima facie evidence of the facts stated in the affidavit.

(8) This paragraph applies to the estates of decedents dying on or after July 1, 1997.
Clause (5) also applies with respect to all notices served on the commissioner of human
services before July 1, 1997, under Laws 1996, chapter 451, article 2, section 55. All notices
served on the commissioner before July 1, 1997, pursuant to Laws 1996, chapter 451, article
2, section 55, shall be deemed to be legally sufficient for the purposes for which they were
intended, notwithstanding any errors, omissions or other defects.

Sec. 17. DIRECTION TO COMMISSIONER; REIMBURSEMENT FOR EXTRACORPOREAL MEMBRANE OXYGENATION CANNULATION AS AN OUTPATIENT SERVICE.

The commissioner of human services, in consultation with providers and hospitals, shall
determine the feasibility of an outpatient reimbursement mechanism for medical assistance
coverage of extracorporeal membrane oxygenation (ECMO) cannulation performed outside
an inpatient hospital setting or in a self-contained mobile ECMO unit. If an outpatient
reimbursement mechanism is feasible, then the commissioner of human services shall
develop a recommended payment mechanism. By January 15, 2025, the commissioner of
human services shall submit a recommendation and the required legislative language to the
chairs and ranking minority members of the legislative committees with jurisdiction over
health care finance. If such a payment mechanism is infeasible, the commissioner of human
services shall submit an explanation as to why it is infeasible.