ARTICLE 3

HEALTH CARE

Section 1. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

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

(b) "Income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except that taxable capital gains, to the extent the money has been used to purchase a home, shall not be counted as income.

(c) "Insurance" means health and accident insurance coverage or enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 2. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 7. **Parental responsibility.** Parents with household adjusted gross income equal to or greater than 675 percent of the federal poverty guidelines are responsible for a portion of the cost of services, according to subdivision 8, when:

(1) insurance or other health care benefits pay some but not all of the cost of services; and

(2) no insurance or other health care benefits are available.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 3. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 8. **Contribution amount.** (a) The natural or adoptive parents of a minor child, not including a child determined eligible for medical assistance without consideration of parental income under the Tax Equity and Fiscal Responsibility Act (TEFRA) option or a child accessing home and community-based waiver services, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to chapter 259A or through Title IV-E of the Social Security Act. The parental contribution is a partial or full payment for provided medical services needed by a child with a chronic illness or disability, including diagnosis, therapy, cures, treatment, mitigation, rehabilitation, maintenance, and personal care services.

ARTICLE 6

HEALTH CARE

(b) For households with adjusted gross income equal to or greater than 675 percent of federal poverty guidelines, the commissioner shall compute the parental contribution by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the commissioner shall determine the parental contribution using a sliding fee scale established by the commissioner that begins at 4.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to 5.99 percent of adjusted gross income for households with adjusted gross income up to 975 percent of federal poverty guidelines; and

(2) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution is 7.49 percent of adjusted gross income.

(c) If the child lives with the parent, the commissioner shall reduce the annual adjusted gross income by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 4. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 9. **Household size; contribution adjustments.** (a) The household size used in determining the amount of contribution under subdivision 8 includes natural and adoptive parents and their dependents, including the child receiving services.

(b) The commissioner shall implement adjustments in the contribution amount due to annual changes in the federal poverty guidelines on the first day of July following publication of the changes.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 5. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 10. **Contribution explained in writing.** (a) The commissioner shall explain the contribution in writing to the parents at the time eligibility for services is determined. The parents shall make the contribution on a monthly basis starting with the first month in which the child receives services.

(b) Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse the excess amount to the parents, either by direct reimbursement if the parent is no longer

required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 6. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 11. **Annual review; written notice.** (a) The commissioner must review the monthly contribution amount at least once every 12 months, when there is a change in household size, and when there is a loss of or gain in income from one month to another in excess of ten percent.

(b) The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 7. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 12. **Parents who do not live with each other; contribution.** Parents of a minor child who do not live with each other shall each pay the contribution required under subdivision 8. The commissioner shall deduct an amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under subdivision 8.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 8. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 13. **Parents with more than one child receiving services; contribution.** The commissioner shall not require parents who have more than one child receiving services to pay more than the amount for the child with the highest expenditures. The commissioner shall not require the parent to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 9. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 14. **Insurance coverage.** (a) The commissioner shall increase the contribution under subdivision 8 by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child.

(b) For purposes of this subdivision, "available" means insurance that is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 10. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 15. **Contribution reduction.** (a) The commissioner shall reduce the contribution under subdivision 8 by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal in writing to the insurer, submitted a complaint or appeal in writing to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

(b) A parent who has requested a reduction in the contribution amount under this subdivision must submit proof in the form and manner prescribed by the commissioner or local agency, including but not limited to the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or local agency under this subdivision are not rules subject to chapter 14.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 11. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 16. **Civil actions.** If the parent fails to make appropriate reimbursement as required in subdivisions 7 and 8, the attorney general, at the request of the commissioner, may institute or direct the appropriate county attorney to institute civil action to recover the required reimbursement.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 12. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 17. **Order of payment.** If the parental contribution is for reimbursement for the cost of services to both the local agency and the medical assistance program, the local agency must be reimbursed for the agency's expenses first and the remainder must be deposited in the medical assistance account.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 13. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 18. **Determination; redetermination; notice.** The commissioner shall mail a determination order and written notice of parental fee to the parent at least annually, or more frequently as provided in Minnesota Rules, parts 9550.6220 to 9550.6229. The determination order and notice must contain the following information:

(1) the amount the parent is required to contribute;

(2) the notice of the right to a redetermination and appeal; and

(3) the telephone number of the division at the Department of Human Services that is responsible for redeterminations.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 14. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 19. **Appeals.** (a) A parent may appeal the determination or redetermination of an obligation to make a contribution under this section according to section 256.045. The parent must make a request for a hearing in writing within 30 days of the date the commissioner mails the determination or redetermination order, or within 90 days of the written notice if the parent shows good cause why the request was not submitted within the 30-day time limit. The commissioner must provide the parent with a written notice that acknowledges receipt of the request and notifies the parent of the date of the hearing. While the appeal is pending, the parent has the rights regarding making payment that are provided in Minnesota Rules, part 9550.6235.

(b) If the commissioner's determination or redetermination is affirmed, the parent shall, within 90 calendar days after the date an order is issued under section 256.045, subdivision 5, pay the total amount due from the effective date of the notice of determination or redetermination that was appealed by the parent. If the commissioner's order under this subdivision results in a decrease in the parental fee amount, the commissioner shall credit any payments made by the parent that result in an overpayment to the parent as provided in Minnesota Rules, part 9550.6235, subpart 3.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 15. Minnesota Statutes 2024, section 256.01, subdivision 29, is amended to read:

Subd. 29. **State medical review team.** (a) To ensure the timely processing of determinations of disability by the commissioner's state medical review team under sections 256B.055, subdivisions 7, paragraph (b), and 12, and 256B.057, subdivision 9, the commissioner shall review all medical evidence and seek information from providers, applicants, and enrollees to support the determination of disability where necessary. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

(b) Medical assistance providers must grant the state medical review team access to electronic health records held by the medical assistance providers, when available, to support efficient and accurate disability determinations.

(c) Medicaid providers shall accept electronically signed authorizations to release medical records provided by the state medical review team.

~~(b)~~ (d) Prior to a denial or withdrawal of a requested determination of disability due to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is necessary and appropriate to a determination of disability, and (2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

~~(c)~~ (e) Any appeal made under section 256.045, subdivision 3, of a disability determination made by the state medical review team must be decided according to the timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be immediately reviewed by the chief human services judge.

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

Section 1. Minnesota Statutes 2024, section 256.01, subdivision 29, is amended to read:

Subd. 29. **State medical review team.** (a) To ensure the timely processing of determinations of disability by the commissioner's state medical review team under sections 256B.055, subdivisions 7, paragraph (b), and 12, and 256B.057, subdivision 9, the commissioner shall review all medical evidence and seek information from providers, applicants, and enrollees to support the determination of disability where necessary. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

(b) Medical assistance providers must grant the state medical review team access to electronic health records held by the medical assistance providers, when available, to support efficient and accurate disability determinations.

(c) Medicaid providers shall accept electronically signed authorizations to release medical records provided by the state medical review team.

~~(b)~~ (d) Prior to a denial or withdrawal of a requested determination of disability due to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is necessary and appropriate to a determination of disability, and (2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

~~(c)~~ (e) Any appeal made under section 256.045, subdivision 3, of a disability determination made by the state medical review team must be decided according to the timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be immediately reviewed by the chief human services judge.

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

Sec. 2. Minnesota Statutes 2024, section 256.01, is amended by adding a subdivision to read:

Subd. 29a. **State medical review team; expedited disability determinations.** (a) The commissioner must establish an expedited disability determination process within the state medical review team for applicants in the following high-risk categories:

(1) individuals in a facility who cannot be discharged without home- and community-based services or long-term care supports in place;

(2) individuals experiencing life-threatening medical conditions requiring urgent access to treatment or prescription medication;

(3) individuals diagnosed with a condition listed on the Social Security Administration's Compassionate Allowance List; and

(4) children under the age of two who have screened positive for a rare disease recognized by national medical registries or evidence-based standards.

(b) Hospitals submitting requests under paragraph (a) must complete an application for medical assistance prior to an expedited request and assist patients with returning required documentation necessary to determine disability.

(c) The commissioner must designate staff within the state medical review team to coordinate expedited requests, communicate with county and tribal agencies, and ensure timely electronic transmission of required documentation, including the use of electronic signature platforms.

Sec. 3. Minnesota Statutes 2024, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

(b) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(c) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, nonemergency medical transportation company, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs that meet the requirements of this subdivision;

(4) public transportation, within the meaning of "public transportation" as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472, subdivision 1, paragraph (p).

(d) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30

and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

(e) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

(f) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services.

(g) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (l), clauses (4), (5), (6), and (7).

(h) The commissioner may use an order by the recipient's attending physician, advanced practice registered nurse, physician assistant, or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance

of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

(i) Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency.

(j) Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(k) The administrative agency shall use the level of service process established by the commissioner to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(l) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(m) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (l) according to paragraphs (p) and (q) when the commissioner has developed, made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government.

(n) The commissioner shall:

(1) verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(o) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(p) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (k), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $12.10 for the base rate and $1.43 per mile when provided by a nonemergency medical transportation provider;

(4) $14.30 for the base rate and $1.43 per mile for assisted transport;

(5) $19.80 for the base rate and $1.70 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate for the first 100 miles and an additional $75 for trips over 100 miles and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary.

(q) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in

Sec. 16. Minnesota Statutes 2024, section 256B.14, subdivision 2, is amended to read:

Subd. 2. **Actions to obtain payment.** (a) The state agency shall promulgate rules to determine the ability of responsible relatives to contribute partial or complete payment or repayment of medical assistance furnished to recipients for whom they are responsible. All medical assistance exclusions shall be allowed, and a resource limit of $10,000 for nonexcluded resources shall be implemented. Above these limits, a contribution of one-third of the excess resources shall be required. These rules shall not require payment or repayment when payment would cause undue hardship to the responsible relative or that relative's immediate family. These rules ~~do not apply to~~ must be consistent with the requirements of section 252.27 for parents of children with household adjusted gross income equal to or greater than 675 percent of the federal poverty guidelines whose eligibility for medical assistance was determined without deeming of the parents' resources and income under the Tax Equity and Fiscal Responsibility Act (TEFRA) option or ~~to parents of children accessing~~ access home and community-based waiver services. The county agency shall give the responsible relative notice of the amount of the payment or repayment. If the state agency or county agency finds that notice of the payment obligation was given to the responsible relative, but that the relative failed or refused to pay, a cause of action exists against the

paragraph (p), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (p), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (p), clauses (1) to (7).

(r) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (p) and (q), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(s) The commissioner, when determining reimbursement rates for nonemergency medical transportation under paragraphs (p) and (q), shall exempt all modes of transportation listed under paragraph (l) from Minnesota Rules, part 9505.0445, item R, subitem (2).

(t) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraph (p) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration.

EFFECTIVE DATE. This section is effective January 1, 2026.

responsible relative for that portion of medical assistance granted after notice was given to the responsible relative, which the relative was determined to be able to pay.

(b) The action may be brought by the state agency or the county agency in the county where assistance was granted, for the assistance, together with the costs of disbursements incurred due to the action.

(c) In addition to granting the county or state agency a money judgment, the court may, upon a motion or order to show cause, order continuing contributions by a responsible relative found able to repay the county or state agency. The order shall be effective only for the period of time during which the recipient receives medical assistance from the county or state agency.

EFFECTIVE DATE. This section is effective January 1, 2026.

Sec. 17. Minnesota Statutes 2024, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

Subdivision 1. **Payment reductions for base care services effective July 1, 2009.** ~~(a)~~ Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation.

Subd. 2. **Classification of therapies as basic care services.** ~~Effective July 1, 2010,~~ The commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in ~~this paragraph~~ subdivision 1 shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

Subd. 3. **Payment reductions to managed care plans effective October 1, 2009.** ~~(b)~~ Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction in subdivision 1 effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction in subdivision 1 effective July 1, 2010.

Subd. 4. **Temporary payment reductions effective September 1, 2011.** ~~(c)~~ (a) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

~~(d)~~ (b) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not

Sec. 4. Minnesota Statutes 2024, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

Subdivision 1. **Payment reductions for base care services effective July 1, 2009.** ~~(a)~~ Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation.

Subd. 2. **Classification of therapies as basic care services.** ~~Effective July 1, 2010,~~ The commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in ~~this paragraph~~ subdivision 1 shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

Subd. 3. **Payment reductions to managed care plans effective October 1, 2009.** ~~(b)~~ Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction in subdivision 1 effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction in subdivision 1 effective July 1, 2010.

Subd. 4. **Temporary payment reductions effective September 1, 2011.** ~~(c)~~ (a) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

~~(d)~~ (b) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not

subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

Subd. 5. **Payment increases effective September 1, 2014.** ~~(c)~~ (a) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent.

(b) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this ~~paragraph~~ subdivision.

Subd. 6. **Temporary payment reductions effective July 1, 2014.** ~~(f)~~ Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent.

Subd. 7. **Payment increases effective July 1, 2015.** (a) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates as determined under ~~paragraphs (i) and (j)~~ subdivisions 9 and 10.

~~(g)~~ (b) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015.

(c) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under ~~this~~ paragraph (b).

Subd. 8. **Exempt services.** ~~(h)~~ This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

Subd. 9. **Individually priced items.** ~~(i)~~ (a) Effective for services provided on or after July 1, 2015, the following categories of medical supplies and durable medical equipment shall be individually priced items: customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service.

(b) This ~~paragraph~~ subdivision does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item.

subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

Subd. 5. **Payment increases effective September 1, 2014.** ~~(c)~~ (a) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent.

(b) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this ~~paragraph~~ subdivision.

Subd. 6. **Temporary payment reductions effective July 1, 2014.** ~~(f)~~ Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent.

Subd. 7. **Payment increases effective July 1, 2015.** (a) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates as determined under ~~paragraphs (i) and (j)~~ subdivisions 9 and 10.

~~(g)~~ (b) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015.

(c) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under ~~this~~ paragraph (b).

Subd. 8. **Exempt services.** ~~(h)~~ This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

Subd. 9. **Individually priced items.** ~~(i)~~ (a) Effective for services provided on or after July 1, 2015, the following categories of medical supplies and durable medical equipment shall be individually priced items: customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service.

(b) This ~~paragraph~~ subdivision does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item.

(c) The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.

Subd. 10. **Rate increases effective July 1, 2015.** ~~(j)~~ (a) Effective for services provided on or after July 1, 2015, medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased as follows:

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

~~This~~ (b) Paragraph (a) does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, items provided to dually eligible recipients when Medicare is the primary payer for the item, and individually priced items identified in ~~paragraph (i)~~ subdivision 9.

(c) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the rate increases in this ~~paragraph~~ subdivision.

Subd. 11. **Rates for ventilators.** ~~(k)~~ (a) Effective for nonpressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or the Medicare fee schedule rate.

(b) Effective for pressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or 47 percent above the Medicare fee schedule rate.

(c) For payments made in accordance with this ~~paragraph~~ subdivision, if, and to the extent that, the commissioner identifies that the state has received federal financial participation for ventilators in excess of the amount allowed effective January 1, 2018, under United States Code, title 42, section 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state funds and maintain the full payment rate under this ~~paragraph~~ subdivision.

Subd. 12. **Rates subject to the upper payment limit.** ~~(l)~~ Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall not be applied to the items listed in this ~~paragraph~~ subdivision.

Subd. 13. **Temporary rates for enteral nutrition and supplies.** ~~(m)~~ (a) For dates of service on or after July 1, 2023, through June 30, ~~2025~~ 2027, enteral nutrition and supplies must be paid according to this ~~paragraph~~ subdivision. If sufficient data exists for a product

(c) The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.

Subd. 10. **Rate increases effective July 1, 2015.** ~~(j)~~ (a) Effective for services provided on or after July 1, 2015, medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased as follows:

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

~~This~~ (b) Paragraph (a) does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, items provided to dually eligible recipients when Medicare is the primary payer for the item, and individually priced items identified in ~~paragraph (i)~~ subdivision 9.

(c) Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the rate increases in this ~~paragraph~~ subdivision.

Subd. 11. **Rates for ventilators.** ~~(k)~~ (a) Effective for nonpressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or the Medicare fee schedule rate.

(b) Effective for pressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or 47 percent above the Medicare fee schedule rate.

(c) For payments made in accordance with this ~~paragraph~~ subdivision, if, and to the extent that, the commissioner identifies that the state has received federal financial participation for ventilators in excess of the amount allowed effective January 1, 2018, under United States Code, title 42, section 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state funds and maintain the full payment rate under this ~~paragraph~~ subdivision.

Subd. 12. **Rates subject to the upper payment limit.** ~~(l)~~ Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall not be applied to the items listed in this ~~paragraph~~ subdivision.

Subd. 13. **Temporary rates for enteral nutrition and supplies.** ~~(m)~~ (a) For dates of service on or after July 1, 2023, through June 30, ~~2025~~ 2027, enteral nutrition and supplies must be paid according to this ~~paragraph~~ subdivision. If sufficient data exists for a product

or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous fiscal year's rate per code and product combination. Data are sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the commissioner has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment rate must be the payment rate in effect on June 30, 2023.

(b) This subdivision expires June 30, 2027.

Subd. 14. **Rates for enteral nutrition and supplies.** ~~(a)~~ For dates of service on or after July 1, ~~2025~~ 2027, enteral nutrition and supplies must be paid according to this ~~paragraph~~ subdivision and updated annually each January 1. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner for the previous calendar year, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous year's rate per code and product combination. Data are sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the commissioner has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment must be the manufacturer's suggested retail price of that product or supply minus 20 percent. If the manufacturer's suggested retail price is not available, payment must be the actual acquisition cost of that product or supply plus 20 percent.

or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous fiscal year's rate per code and product combination. Data are sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the commissioner has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment rate must be the payment rate in effect on June 30, 2023.

(b) This subdivision expires June 30, 2027.

Subd. 14. **Rates for enteral nutrition and supplies.** ~~(a)~~ For dates of service on or after July 1, ~~2025~~ 2027, enteral nutrition and supplies must be paid according to this ~~paragraph~~ subdivision and updated annually each January 1. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the commissioner for the previous calendar year, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous year's rate per code and product combination. Data are sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the commissioner has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment must be the manufacturer's suggested retail price of that product or supply minus 20 percent. If the manufacturer's suggested retail price is not available, payment must be the actual acquisition cost of that product or supply plus 20 percent.

Sec. 5. **SINGLE ADMINISTRATIVE STRUCTURE AND DELIVERY SYSTEM PILOT PROGRAM.**

(a) By January 1, 2026, the commissioner of human services, in coordination with the commissioner of transportation, must implement one or two pilot programs for a web-based single administrative structure and delivery system for nonemergency medical transportation under medical assistance and MinnesotaCare. The administrative structure and delivery system must meet the requirements in paragraph (b). Each pilot program must include at least two counties. Metropolitan counties, as defined in Minnesota Statutes, section 473.121, subdivision 4, are not eligible to participate. Each pilot program shall operate for three years from the date of implementation.

(b) The web-based single administrative structure and delivery system must provide for the following:

(1) bidirectional communication between payers and transportation providers;

(2) client and client advocate access to ride scheduling and real-time trip monitoring;

(3) real-time eligibility and level of service determination;

(4) on-demand reporting;

(5) expedited payments for transportation providers; and

(6) the ability to collect feedback, including but not limited to complaints regarding inappropriate level of needs determinations, utilization of inappropriate transportation modes, and interference with accessing nonemergency medical transportation.

(c) By February 1, 2027, and each year thereafter that a pilot program is in effect, the commissioner must submit a report on the pilot programs to the chairs and ranking minority members of the legislative committees with jurisdiction over nonemergency medical transportation under medical assistance and MinnesotaCare.