

80.16 **ARTICLE 3**

80.17 **HEALTH CARE**

80.18 Section 1. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision

80.19 to read:

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

80.21 meanings given.

80.22 (b) "Income" means the adjusted gross income of the natural or adoptive parents

80.23 determined according to the previous year's federal tax form, except that taxable capital

80.24 gains, to the extent the money has been used to purchase a home, shall not be counted as

80.25 income.

80.26 (c) "Insurance" means health and accident insurance coverage or enrollment in a nonprofit

80.27 health service plan, health maintenance organization, self-insured plan, or preferred provider

80.28 organization.

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

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

81.2 read:

81.3 Subd. 7. **Parental responsibility.** Parents with household adjusted gross income equal

81.4 to or greater than 675 percent of the federal poverty guidelines are responsible for a portion

81.5 of the cost of services, according to subdivision 8, when:

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

81.7 and

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

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

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

81.11 read:

81.12 Subd. 8. **Contribution amount.** (a) The natural or adoptive parents of a minor child,

81.13 not including a child determined eligible for medical assistance without consideration of

81.14 parental income under the Tax Equity and Fiscal Responsibility Act (TEFRA) option or a

81.15 child accessing home and community-based waiver services, must contribute to the cost of

81.16 services used by making monthly payments on a sliding scale based on income, unless the

81.17 child is married or has been married, parental rights have been terminated, or the child's

81.18 adoption is subsidized according to chapter 259A or through Title IV-E of the Social Security

81.19 Act. The parental contribution is a partial or full payment for provided medical services

81.20 needed by a child with a chronic illness or disability, including diagnosis, therapy, cures,

81.21 treatment, mitigation, rehabilitation, maintenance, and personal care services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

84.15 (2) the insurer denied insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

86.3 (b) If the commissioner's determination or redetermination is affirmed, the parent shall,
86.4 within 90 calendar days after the date an order is issued under section 256.045, subdivision
86.5 5, pay the total amount due from the effective date of the notice of determination or
86.6 redetermination that was appealed by the parent. If the commissioner's order under this
86.7 subdivision results in a decrease in the parental fee amount, the commissioner shall credit
86.8 any payments made by the parent that result in an overpayment to the parent as provided
86.9 in Minnesota Rules, part 9550.6235, subpart 3.

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

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

86.12 Subd. 29. **State medical review team.** (a) To ensure the timely processing of
86.13 determinations of disability by the commissioner's state medical review team under sections
86.14 256B.055, subdivisions 7, paragraph (b), and 12, and 256B.057, subdivision 9, the
86.15 commissioner shall review all medical evidence and seek information from providers,
86.16 applicants, and enrollees to support the determination of disability where necessary. Disability
86.17 shall be determined according to the rules of title XVI and title XIX of the Social Security
86.18 Act and pertinent rules and policies of the Social Security Administration.

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

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

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

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

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

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

188.13 Subd. 29. **State medical review team.** (a) To ensure the timely processing of
188.14 determinations of disability by the commissioner's state medical review team under sections
188.15 256B.055, subdivisions 7, paragraph (b), and 12, and 256B.057, subdivision 9, the
188.16 commissioner shall review all medical evidence and seek information from providers,
188.17 applicants, and enrollees to support the determination of disability where necessary. Disability
188.18 shall be determined according to the rules of title XVI and title XIX of the Social Security
188.19 Act and pertinent rules and policies of the Social Security Administration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

190.27 (2) the provider has initiated background studies on the individuals specified in section
190.28 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

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

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

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

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

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

191.15 (h) The commissioner may use an order by the recipient's attending physician, advanced
191.16 practice registered nurse, physician assistant, or a medical or mental health professional to
191.17 certify that the recipient requires nonemergency medical transportation services.

191.18 Nonemergency medical transportation providers shall perform driver-assisted services for
191.19 eligible individuals, when appropriate. Driver-assisted service includes passenger pickup
191.20 at and return to the individual's residence or place of business, assistance with admittance

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

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

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

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

192.5 (l) The covered modes of transportation are:

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

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

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

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

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

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

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

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

192.32 (n) The commissioner shall:

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

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

193.3 (3) investigate all complaints and appeals.

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

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

193.13 (1) \$0.22 per mile for client reimbursement;

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

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

193.19 (4) \$14.30 for the base rate and \$1.43 per mile for assisted transport;

193.20 (5) \$19.80 for the base rate and \$1.70 per mile for lift-equipped/ramp transport;

193.21 (6) \$75 for the base rate for the first 100 miles and an additional \$75 for trips over 100
193.22 miles and \$2.40 per mile for protected transport; and

193.23 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
193.24 an additional attendant if deemed medically necessary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

88.2 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

88.3 Subdivision 1. **Payment reductions for base care services effective July 1, 2009.** ~~(a)~~
88.4 Effective for services provided on or after July 1, 2009, total payments for basic care services,
88.5 shall be reduced by three percent, except that for the period July 1, 2009, through June 30,
88.6 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general
88.7 assistance medical care programs, prior to third-party liability and spenddown calculation.

88.8 Subd. 2. **Classification of therapies as basic care services.** ~~Effective July 1, 2010,~~ The
88.9 commissioner shall classify physical therapy services, occupational therapy services, and
88.10 speech-language pathology and related services as basic care services. The reduction in ~~this~~
88.11 ~~paragraph~~ subdivision 1 shall apply to physical therapy services, occupational therapy
88.12 services, and speech-language pathology and related services provided on or after July 1,
88.13 2010.

88.14 Subd. 3. **Payment reductions to managed care plans effective October 1, 2009.** ~~(b)~~
88.15 Payments made to managed care plans and county-based purchasing plans shall be reduced
88.16 for services provided on or after October 1, 2009, to reflect the reduction in subdivision 1
88.17 effective July 1, 2009, and payments made to the plans shall be reduced effective October
88.18 1, 2010, to reflect the reduction in subdivision 1 effective July 1, 2010.

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

88.23 ~~(a)~~ (b) Effective for services provided on or after September 1, 2011, through June 30,
88.24 2013, total payments for ambulatory surgery centers facility fees, medical supplies and
88.25 durable medical equipment not subject to a volume purchase contract, prosthetics and
88.26 orthotics, renal dialysis services, laboratory services, public health nursing services, physical
88.27 therapy services, occupational therapy services, speech therapy services, eyeglasses not

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

194.19 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

194.20 Subdivision 1. **Payment reductions for base care services effective July 1, 2009.** ~~(a)~~
194.21 Effective for services provided on or after July 1, 2009, total payments for basic care services,
194.22 shall be reduced by three percent, except that for the period July 1, 2009, through June 30,
194.23 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general
194.24 assistance medical care programs, prior to third-party liability and spenddown calculation.

194.25 Subd. 2. **Classification of therapies as basic care services.** ~~Effective July 1, 2010,~~ The
194.26 commissioner shall classify physical therapy services, occupational therapy services, and
194.27 speech-language pathology and related services as basic care services. The reduction in ~~this~~
194.28 ~~paragraph~~ subdivision 1 shall apply to physical therapy services, occupational therapy
194.29 services, and speech-language pathology and related services provided on or after July 1,
194.30 2010.

194.31 Subd. 3. **Payment reductions to managed care plans effective October 1, 2009.** ~~(b)~~
194.32 Payments made to managed care plans and county-based purchasing plans shall be reduced
194.33 for services provided on or after October 1, 2009, to reflect the reduction in subdivision 1
195.1 effective July 1, 2009, and payments made to the plans shall be reduced effective October
195.2 1, 2010, to reflect the reduction in subdivision 1 effective July 1, 2010.

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

195.7 ~~(a)~~ (b) Effective for services provided on or after September 1, 2011, through June 30,
195.8 2013, total payments for ambulatory surgery centers facility fees, medical supplies and
195.9 durable medical equipment not subject to a volume purchase contract, prosthetics and
195.10 orthotics, renal dialysis services, laboratory services, public health nursing services, physical
195.11 therapy services, occupational therapy services, speech therapy services, eyeglasses not

88.28 subject to a volume purchase contract, hearing aids not subject to a volume purchase contract,
88.29 and anesthesia services shall be reduced by three percent from the rates in effect on August
88.30 31, 2011.

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

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

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

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

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

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

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

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

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

195.12 subject to a volume purchase contract, hearing aids not subject to a volume purchase contract,
195.13 and anesthesia services shall be reduced by three percent from the rates in effect on August
195.14 31, 2011.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

91.4 or supply, payment must be based upon the 50th percentile of the usual and customary
91.5 charges per product code submitted to the commissioner, using only charges submitted per
91.6 unit. Increases in rates resulting from the 50th percentile payment method must not exceed
91.7 150 percent of the previous fiscal year's rate per code and product combination. Data are
91.8 sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different
91.9 providers for a given product or supply; or (2) in the absence of the data in clause (1), the
91.10 commissioner has at least 20 claim lines by at least five different providers for a product or
91.11 supply that does not meet the requirements of clause (1). If sufficient data are not available
91.12 to calculate the 50th percentile for enteral products or supplies, the payment rate must be
91.13 the payment rate in effect on June 30, 2023.

91.14 (b) This subdivision expires June 30, 2027.

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

197.23 or supply, payment must be based upon the 50th percentile of the usual and customary
197.24 charges per product code submitted to the commissioner, using only charges submitted per
197.25 unit. Increases in rates resulting from the 50th percentile payment method must not exceed
197.26 150 percent of the previous fiscal year's rate per code and product combination. Data are
197.27 sufficient if: (1) the commissioner has at least 100 paid claim lines by at least ten different
197.28 providers for a given product or supply; or (2) in the absence of the data in clause (1), the
197.29 commissioner has at least 20 claim lines by at least five different providers for a product or
197.30 supply that does not meet the requirements of clause (1). If sufficient data are not available
197.31 to calculate the 50th percentile for enteral products or supplies, the payment rate must be
197.32 the payment rate in effect on June 30, 2023.

197.33 (b) This subdivision expires June 30, 2027.

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

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

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

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

198.28 (1) bidirectional communication between payers and transportation providers;

- 198.29 (2) client and client advocate access to ride scheduling and real-time trip monitoring;
- 198.30 (3) real-time eligibility and level of service determination;
- 198.31 (4) on-demand reporting;
- 198.32 (5) expedited payments for transportation providers; and
- 199.1 (6) the ability to collect feedback, including but not limited to complaints regarding
- 199.2 inappropriate level of needs determinations, utilization of inappropriate transportation modes,
- 199.3 and interference with accessing nonemergency medical transportation.
- 199.4 (c) By February 1, 2027, and each year thereafter that a pilot program is in effect, the
- 199.5 commissioner must submit a report on the pilot programs to the chairs and ranking minority
- 199.6 members of the legislative committees with jurisdiction over nonemergency medical
- 199.7 transportation under medical assistance and MinnesotaCare.