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ARTICLE 5

HEALTH CARE FINANCE

Section 1. Minnesota Statutes 2024, section 62A.673, subdivision 2, is amended to read:

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

(b) "Distant site" means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.

(c) "Health care provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law. A health care provider includes a mental health professional under section 245I.04, subdivision 2; a mental health practitioner under section 245I.04, subdivision 4; a clinical trainee under section 245I.04, subdivision 6; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

(d) "Health carrier" has the meaning given in section 62A.011, subdivision 2.

(e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

(f) "Originating site" means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth. For purposes of store-and-forward technology, the originating site also means the location at which a health care provider transfers or transmits information to the distant site.

(g) "Store-and-forward technology" means the asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

(h) "Telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Until July 1, ~~2025~~ 2028, telehealth also includes audio-only communication between a health care provider and a patient ~~in accordance with subdivision 6, paragraph (b)~~ if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication or if, for substance use disorder treatment services and mental health care services delivered through telehealth by

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ARTICLE 6

HUMAN SERVICES HEALTH CARE FINANCE

Section 1. Minnesota Statutes 2024, section 62A.673, subdivision 2, is amended to read:

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

(b) "Distant site" means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.

(c) "Health care provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law. A health care provider includes a mental health professional under section 245I.04, subdivision 2; a mental health practitioner under section 245I.04, subdivision 4; a clinical trainee under section 245I.04, subdivision 6; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

(d) "Health carrier" has the meaning given in section 62A.011, subdivision 2.

(e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

(f) "Originating site" means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth. For purposes of store-and-forward technology, the originating site also means the location at which a health care provider transfers or transmits information to the distant site.

(g) "Store-and-forward technology" means the asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

(h) "Telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Until July 1, ~~2025~~ 2028, telehealth also includes audio-only communication between a health care provider and a patient ~~in accordance with subdivision 6, paragraph (b)~~ if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication or if, for substance use disorder treatment services and mental health care services delivered through telehealth by

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means of audio-only communication, the communication was initiated by the enrollee while in an emergency or crisis situation and a scheduled appointment was not possible due to the need of an immediate response. Telehealth does not include communication between health care providers that consists solely of a telephone conversation, email, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an email or facsimile transmission. Telehealth does not include telemonitoring services as defined in paragraph (i).

(i) "Telemonitoring services" means the remote monitoring of clinical data related to the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect an enrollee's health-related data for the purpose of assisting a health care provider in assessing and monitoring the enrollee's medical condition or status.

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

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means of audio-only communication, the communication was initiated by the enrollee while in an emergency or crisis situation and a scheduled appointment was not possible due to the need of an immediate response. Telehealth does not include communication between health care providers that consists solely of a telephone conversation, email, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an email or facsimile transmission. Telehealth does not include telemonitoring services as defined in paragraph (i).

(i) "Telemonitoring services" means the remote monitoring of clinical data related to the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect an enrollee's health-related data for the purpose of assisting a health care provider in assessing and monitoring the enrollee's medical condition or status.

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

Sec. 2. Minnesota Statutes 2024, section 62M.17, subdivision 2, is amended to read:

Subd. 2. **Effect of change in prior authorization clinical criteria.** (a) If, during a plan year, or a calendar year for fee-for-service providers under chapters 256B and 256L, a utilization review organization changes coverage terms for a health care service or the clinical criteria used to conduct prior authorizations for a health care service, the change in coverage terms or change in clinical criteria shall not apply until the next plan year, or the next calendar year for fee-for-service providers under chapters 256B and 256L, for any enrollee who received prior authorization for a health care service using the coverage terms or clinical criteria in effect before the effective date of the change.

(b) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a drug or device that has been deemed unsafe by the United States Food and Drug Administration (FDA); that has been withdrawn by either the FDA or the product manufacturer; or when an independent source of research, clinical guidelines, or evidence-based standards has issued drug- or device-specific warnings or recommended changes in drug or device usage.

(c) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service when an independent source of research, clinical guidelines, or evidence-based standards has recommended changes in usage of the service for reasons related to patient harm. This paragraph expires December 31, 2025, for health benefit plans offered, sold, issued, or renewed on or after that date.

(d) Effective January 1, 2026, and applicable to health benefit plans offered, sold, issued, or renewed on or after that date, paragraph (a) does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service when an independent source of research, clinical guidelines,

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Sec. 2. Minnesota Statutes 2024, section 174.30, subdivision 3, is amended to read:

Subd. 3. **Other standards; wheelchair securement; protected transport.** (a) A special transportation service that transports individuals occupying wheelchairs is subject to the provisions of sections 299A.11 to 299A.17 concerning wheelchair securement devices. The commissioners of transportation and public safety shall cooperate in the enforcement of this section and sections 299A.11 to 299A.17 so that a single inspection is sufficient to ascertain compliance with sections 299A.11 to 299A.17 and with the standards adopted under this section. Representatives of the Department of Transportation may inspect wheelchair securement devices in vehicles operated by special transportation service providers to determine compliance with sections 299A.11 to 299A.17 and to issue certificates under section 299A.14, subdivision 4.

(b) In place of a certificate issued under section 299A.14, the commissioner may issue a decal under subdivision 4 for a vehicle equipped with a wheelchair securement device if the device complies with sections 299A.11 to 299A.17 and the decal displays the information in section 299A.14, subdivision 4.

(c) For vehicles designated as protected transport under section 256B.0625, subdivision 17, paragraph ~~(l)~~ (n), the commissioner of transportation, during the commissioner's inspection, shall check to ensure the safety provisions contained in that paragraph are in working order.

Sec. 3. Minnesota Statutes 2024, section 256.9657, subdivision 2, is amended to read:

Subd. 2. **Hospital surcharge.** (a) Effective October 1, 1992, each Minnesota hospital except facilities of the federal Indian Health Service and regional treatment centers shall pay to the ~~medical assistance account~~ health care access fund a surcharge equal to 1.4 percent of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.

(b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56 percent.

(c) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

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or evidence-based standards has recommended changes in usage of the service for reasons related to previously unknown and imminent patient harm.

(e) Paragraph (a) does not apply if a utilization review organization removes a brand name drug from its formulary or places a brand name drug in a benefit category that increases the enrollee's cost, provided the utilization review organization (1) adds to its formulary a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA Purple Book, at a lower cost to the enrollee, and (2) provides at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

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Sec. 4. Minnesota Statutes 2024, section 256.9657, is amended by adding a subdivision to read:

Subd. 2b. **Hospital assessment.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "eligible hospital" means a hospital:

(i) licensed under section 144.50;

(ii) located in Minnesota; and

(iii) with a Medicare cost report filed and showing in the Healthcare Cost Report Information System (HCRIS);

(2) "net outpatient revenue" means the value to reflect total outpatient revenue less Medicare revenue as calculated from Worksheet G of the hospital's Medicare cost report; and

(3) "total patient days" means the value to reflect total hospital inpatient days as reported on Worksheet S-3 of the hospital's Medicare cost report.

(b) Subject to paragraphs (k) to (n), each eligible hospital must pay assessments to the hospital directed payment program account, with an aggregate annual assessment amount equal to the sum of the following:

(1) $120.22 multiplied by total patient days; and

(2) 5.96 percent of the hospital's net outpatient revenue.

(c) The assessment amount for calendar years 2026 and 2027 must be based on the total patient days and net outpatient revenue reflected on an eligible hospital's Medicare cost report as follows:

(1) an eligible hospital with a fiscal year ending on March 31 or June 30 must use data from a cost report from hospital fiscal year 2022; and

(2) an eligible hospital with a fiscal year ending on September 30 or December 31 must use data from a cost report from hospital fiscal year 2021.

The annual assessment amount for calendar years after 2027 must be set for a two-year period and must be based on the total patient days and net outpatient revenue reflected on an eligible hospital's most recent Medicare cost report filed and showing in HCRIS as of August 1 of the year prior to the subsequent two-year period.

(d) The commissioner may, after consultation with the Minnesota Hospital Association, modify the rates of assessment in paragraph (b) as necessary to comply with federal law,

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Sec. 3. Minnesota Statutes 2024, section 256.9657, is amended by adding a subdivision to read:

Subd. 2b. **Hospital assessment.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "eligible hospital" means a hospital licensed under section 144.50 and located in Minnesota;

(2) "net outpatient revenue" means the value reflecting total outpatient revenue less Medicare revenue as calculated from Worksheet G of the hospital's most recent Medicare cost report filed and showing in the Healthcare Cost Report Information System (HCRIS) as of August 1 of each year; and

(3) "total patient days" means the value reflecting total hospital inpatient days as reported on Worksheet S-3 of the hospital's most recent Medicare cost report filed and showing in HCRIS as of August 1 of each year.

(b) Subject to paragraphs (m) to (o), each eligible hospital must pay to the hospital directed payment program account assessments in an aggregate annual amount equal to the sum of the following:

(1) $120.22 multiplied by total patient days; and

(2) 5.96 percent of the hospital's net outpatient revenue.

(c) The assessment amount for calendar years 2026 and 2027 must be based on the total patient days and net outpatient revenue in 2021 for each eligible hospital.

(d) The commissioner may, after consultation with the Minnesota Hospital Association, modify the rates of assessment in paragraph (b) as necessary to comply with federal law,

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obtain or maintain a waiver under Code of Federal Regulations, title 42, section 433.72, or otherwise maximize under this section federal financial participation for medical assistance.

(e) Eligible hospitals must pay the annual assessment amount under paragraph (b) to the commissioner by paying four equal, quarterly assessments. Eligible hospitals must pay the quarterly assessments by January 1, April 1, July 1, and October 1 each year. Assessments must be paid in the form and manner specified by the commissioner. An eligible hospital is prohibited from paying a quarterly assessment until the eligible hospital has received the applicable invoice under paragraph (f).

(f) The commissioner must provide eligible hospitals with an invoice by December 1 for the assessment due January 1, March 1 for the assessment due April 1, June 1 for the assessment due July 1, and September 1 for the assessment due October 1 each year.

(g) The commissioner must notify each eligible hospital of its estimated annual assessment amount for the subsequent calendar year by October 15 each year.

(h) If any of the dates for assessments or invoices in paragraphs (d) to (f) fall on a holiday, the applicable date is the next business day.

(i) A hospital that has merged with another hospital must have the hospital's assessment revised at the start of the first full fiscal year after the merger is complete. A closed hospital is retroactively responsible for assessments owed for services provided through the final date of operations.

(j) If the commissioner determines that a hospital has underpaid or overpaid an assessment, the commissioner must notify the hospital of the unpaid assessment or of any refund due.

(k) Revenue from an assessment under this subdivision must only be used by the commissioner to pay the nonfederal share of the directed payment program under section 256B.1974.

(l) The commissioner is prohibited from collecting any assessment under this subdivision during any period of time when:

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obtain or maintain a waiver under Code of Federal Regulations, title 42, section 433.72, or to otherwise maximize under this section federal financial participation for medical assistance. Notwithstanding the foregoing authorization to maximize federal financial participation for medical assistance, the commissioner must reduce the rates of assessment in paragraph (b) as necessary to ensure:

(1) the state's aggregated health care-related taxes on inpatient hospital services do not exceed five percent of the net patient revenue attributable to those services; and

(2) the state's aggregated health care-related taxes on outpatient hospital services do not exceed five percent of the net patient revenue attributable to those services.

(e) Eligible hospitals must pay the annual assessment amount under paragraph (b) to the commissioner by paying four equal quarterly assessments. Eligible hospitals must pay the quarterly assessments by January 1, April 1, July 1, and October 1 each year. Eligible hospitals must pay the assessments in the form and manner specified by the commissioner. An eligible hospital is prohibited from paying a quarterly assessment until the eligible hospital has received the applicable invoice under paragraph (f). The commissioner may make the assessment retroactive to the first quarter for which federal approval is effective.

(f) The commissioner must provide eligible hospitals with an invoice by December 1 for the assessment due January 1, March 1 for the assessment due April 1, June 1 for the assessment due July 1, and September 1 for the assessment due October 1 each year.

(g) The commissioner must notify each eligible hospital of its estimated annual assessment amount for the subsequent calendar year by October 15 each year.

(h) If any of the dates for assessments or invoices in paragraphs (e) to (g) fall on a holiday, the applicable date is the next business day.

(i) A hospital is not required to pay an assessment under this subdivision until the start of the first full fiscal year the hospital is an eligible hospital. A hospital that has merged with another hospital must have the hospital's assessment revised at the start of the first full fiscal year after the merger is complete. A closed hospital is retroactively responsible for assessments owed for services provided through the final date of operations.

(j) If the commissioner determines that a hospital has underpaid or overpaid an assessment, the commissioner must notify the hospital of the unpaid assessment or of any refund due.

(k) Revenue from an assessment under this subdivision must only be used by the commissioner to pay the nonfederal share of the directed payment program under section 256B.1974.

(l) The commissioner is prohibited from collecting any assessment under this subdivision during any period of time when:

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(1) federal financial participation is unavailable or disallowed, or if the approved federal financial participation for the directed payment under section 256B.1974 is less than 51 percent; or

(2) a directed payment under section 256B.1974 is not approved by the Centers for Medicare and Medicaid Services.

(m) The commissioner must make the following discounts from the inpatient portion of the assessment under paragraph (b), clause (1), in the stated amount or as necessary to achieve federal approval of the assessment in this section:

(1) Hennepin Healthcare, with a discount of 25 percent off the inpatient portion of the assessment rate;

(2) Mayo Rochester, with a discount of ten percent off the inpatient portion of the assessment rate;

(3) Gillette Children's Hospital, with a discount of 90 percent off the inpatient portion of the assessment rate;

(4) each hospital not included in another discount category, and with greater than $200,000,000 in total medical assistance inpatient and outpatient revenue in fee-for-service and managed care, as reported in the state fiscal year 2022 Medicare cost report, with a discount of five percent off the inpatient portion of the assessment rate; and

(5) a discount off the inpatient portion of the assessment rate, as is necessary, in order to ensure that no single hospital is responsible for greater than 12 percent of the total assessment annually collected statewide.

(n) The commissioner must make the following discounts from the outpatient portion of the assessment under paragraph (b), clause (2), in the stated amount or as necessary to achieve federal approval of the assessment in this section:

(1) each critical access hospital or independent hospital located outside a city of the first class and paid under the Medicare prospective payment system, with a discount of 40 percent off the outpatient portion of the assessment rate;

(2) Gillette Children's Hospital, with a discount of 90 percent off the outpatient portion of the assessment rate;

(3) Hennepin Healthcare, with a discount of 60 percent off the outpatient portion of the assessment rate;

(4) Mayo Rochester, with a discount of 20 percent off the outpatient portion of the assessment rate; and

(5) each hospital not included in another discount category, and with greater than $200,000,000 in total medical assistance inpatient and outpatient revenue in fee-for-service

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(1) federal financial participation is unavailable, disallowed, or reduced by at least 15 percent relative to the state's share of medical assistance as of April 1, 2025; or

(2) a directed payment under section 256B.1974 is not approved by the Centers for Medicare and Medicaid Services.

(m) The commissioner must make the following discounts from the inpatient portion of the assessment under paragraph (b), clause (1), in the stated amount or as necessary to achieve federal approval of the assessment in this section:

(1) for Hennepin Healthcare, a discount of 25 percent off the inpatient portion of the assessment rate;

(2) for Mayo Rochester, a discount of ten percent off the inpatient portion of the assessment rate; and

(3) for Gillette Children's Hospital, a discount of 90 percent off the inpatient portion of the assessment rate.

(n) The commissioner must make the following discounts from the outpatient portion of the assessment under paragraph (b), clause (2), in the stated amount or as necessary to achieve federal approval of the assessment in this section:

(1) for each critical access hospital or independent hospital located outside a city of the first class and paid under the Medicare prospective payment system, a discount of 40 percent off the outpatient portion of the assessment rate;

(2) for Gillette Children's Hospital, a discount of 90 percent off the outpatient portion of the assessment rate;

(3) for Hennepin Healthcare, a discount of 60 percent off the outpatient portion of the assessment rate; and

(4) for Mayo Rochester, a discount of 20 percent off the outpatient portion of the assessment rate.

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and managed care, as reported in the state fiscal year 2022 Medicare cost report, with a discount of ten percent off the outpatient portion of the assessment rate.

(o) The commissioner must fully exempt the following from the assessment in this section:

(1) federal Indian Health Service facilities;

(2) state-owned or state-operated regional treatment centers and all state-operated services;

(3) federal Veterans Administration Medical Centers; and

(4) long-term acute care hospitals.

(p) If the federal share of the hospital directed payment program under section 256B.1974 is increased as the result of an increase to the federal medical assistance percentage, the commissioner must reduce the assessment on a uniform percentage basis across eligible hospitals on which the assessment is imposed, such that the aggregate amount collected from hospitals under this subdivision does not exceed the total amount needed to maintain the same aggregate state and federal funding level for the directed payments authorized by section 256B.1974.

(q) Hospitals subject to the assessment under this subdivision must submit to the commissioner on an annual basis, in the form and manner specified by the commissioner in consultation with the Minnesota Hospital Association, all documentation necessary to determine the assessment amounts under this subdivision.

EFFECTIVE DATE. (a) This section is effective the later of January 1, 2026, or federal approval of all of the following:

(1) the waiver for the assessment required under this section; and

(2) the amendments in this act to Minnesota Statutes, sections 256B.1973 and 256B.1974.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

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(o) The commissioner must fully exempt the following from the assessment in this section:

(1) federal Indian Health Service facilities;

(2) state-owned or state-operated regional treatment centers and all state-operated services;

(3) federal Veterans Administration Medical Centers; and

(4) long-term acute care hospitals.

(p) If the federal share of the hospital directed payment program under section 256B.1974 is increased as the result of an increase to the federal medical assistance percentage, then the commissioner must reduce the assessment on a uniform percentage basis across eligible hospitals on which the assessment is imposed, such that the aggregate amount collected from hospitals under this subdivision does not exceed the total amount needed to maintain the same aggregate state and federal funding level for the directed payments authorized by section 256B.1974.

(q) Hospitals subject to the assessment under this subdivision must submit to the commissioner on an annual basis, in the form and manner specified by the commissioner in consultation with the Minnesota Hospital Association, all documentation necessary to determine the assessment amounts under this subdivision.

(r) Any disproportionate share hospital payments that are supplanted due to the implementation of the hospital directed payment program under section 256B.1974 must be redirected into the hospital directed payment program as an offset to the assessment under this section owed by all medical assistance disproportionate share hospitals as defined in section 256.969, subdivision 9, and reduce their assessments on a uniform basis.

(s) Any future state funding sources identified and used toward the hospital directed payment program under section 256B.1974 may be used to offset the assessment under this section.

EFFECTIVE DATE. (a) This section is effective the later of January 1, 2026, or federal approval of all of the following:

(1) this section; and

(2) the amendments in this act to Minnesota Statutes, sections 256B.1973 and 256B.1974.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 4. Minnesota Statutes 2024, section 256.969, subdivision 2b, is amended to read:

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

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

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

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

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

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

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

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

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

(1) pediatric services;

(2) behavioral health services;

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

(4) transplant services;

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

(6) outlier admissions;

(7) low-volume providers; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) geographic location.

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

(l) Effective for discharges occurring on or after January 1, 2028, or on or after the date of federal approval, whichever is later, the commissioner must increase by an annual aggregate amount of $10,000,000:

(1) payments for inpatient behavioral health services provided by hospitals paid under the DRG methodology by increasing the adjustment for behavioral health services under section 256.969, subdivision 2b, paragraph (e); and

(2) capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increase provided under this paragraph. Managed care and county-based purchasing plans must use the capitation rate increase provided under this clause to increase payment rates for inpatient behavioral health services provided by hospitals paid under the DRG methodology. The commissioner must monitor the effect of this rate increase on enrollee access to behavioral health services. If for any contract year federal approval is not received for this clause, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this clause. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this clause. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph.

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

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Sec. 5. Minnesota Statutes 2024, section 256.969, subdivision 2f, is amended to read:

Subd. 2f. **Alternate inpatient payment rate.** (a) Effective January 1, 2022, for a hospital eligible to receive disproportionate share hospital payments under subdivision 9, paragraph (d), clause (6), the commissioner shall reduce the amount calculated under subdivision 9, paragraph (d), clause (6), by 99 percent and compute an alternate inpatient payment rate. The alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to what the hospital would have received for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance had the hospital received the entire amount calculated under subdivision 9, paragraph (d), clause (6). This paragraph expires when paragraph (b) becomes effective.

(b) For hospitals eligible to receive payment under section 256B.1973 or 256B.1974 and meeting the criteria in subdivision 9, paragraph (d), the commissioner shall reduce the amount calculated under subdivision 9, paragraph (d), by one percent and compute an alternate inpatient payment rate. The alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to what the hospital would have received for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance had the hospital received 99 percent of the entire amount calculated under subdivision 9, paragraph (d). Hospitals that do not meet federal requirements for Medicaid disproportionate share hospitals are not eligible for this alternate payment.

EFFECTIVE DATE. (a) Paragraph (b) of this section is effective the later of January 1, 2026, or federal approval of all of the following:

(1) this section; and

(2) the amendments in this act to Minnesota Statutes, sections 256B.1973 and 256B.1974.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 6. Minnesota Statutes 2024, section 256B.0371, subdivision 3, is amended to read:

Subd. 3. **Contingent contract with dental administrator.** (a) The commissioner shall determine the extent to which managed care ~~and county-based purchasing~~ plans in the aggregate meet the performance benchmark specified in subdivision 1 for coverage year 2024. If managed care ~~and county-based purchasing~~ plans in the aggregate fail to meet the performance benchmark, the commissioner, after issuing a request for information followed by a request for proposals, shall contract with a dental administrator to administer dental services beginning January 1, ~~2026~~ 2028, for ~~all~~ recipients of medical assistance and

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THE FOLLOWING LANGUAGE WAS MOVED IN FROM SENATE ARTICLE 7, SECTION 2.

Sec. 2. Minnesota Statutes 2024, section 256B.0371, subdivision 3, is amended to read:

Subd. 3. **Contingent contract with dental administrator.** (a) The commissioner shall determine the extent to which managed care and county-based purchasing plans in the aggregate meet the performance benchmark specified in subdivision 1 for coverage year 2024. If managed care and county-based purchasing plans in the aggregate fail to meet the performance benchmark, the commissioner, after issuing a request for information followed by a request for proposals, shall contract with a dental administrator to administer dental services beginning January 1, ~~2026~~ 2030, for all recipients of medical assistance and

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MinnesotaCare~~, including persons~~ who are served under fee-for-service and persons receiving services through managed care ~~and county-based purchasing~~ plans.

(b) The dental administrator must provide administrative services, including but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and reviews of medical necessity for dental services;

(4) dental claims processing;

(5) coordination of dental care with other services;

(6) management of fraud and abuse;

(7) monitoring access to dental services statewide;

(8) performance measurement;

(9) quality improvement and evaluation; ~~and~~

(10) management of third-party liability requirements~~.~~; and

(11) establishment of grievance and appeals processes for providers and enrollees that the commissioner can monitor.

(c) Dental administrator payments to contracted dental providers must be ~~at the~~ based on rates ~~established under sections 256B.76 and 256L.11~~ recommended by the dental access working group. If the recommended rates are not established in law prior to July 1, 2027, then dental administrator payments to contracted dental providers must be at the rates established under sections 256B.76 and 256L.11.

(d) Recipients must be given a choice of dental provider, including any provider who agrees to provider participation requirements and payment rates established by the commissioner and dental administrator. The dental administrator must comply with the network adequacy and geographic access requirements that apply to managed care ~~and county-based purchasing~~ plans for dental services under section 62K.14.

(e) The contract with the dental administrator must include ~~a provision that states that if the dental administrator fails to meet, by calendar year 2029, a performance benchmark under which at least 55 percent of children and adults who were continuously enrolled for at least 11 months in either medical assistance or MinnesotaCare received at least one dental visit during the calendar year, the contract must be terminated and the commissioner must enter into a contract with a new dental administrator as soon as practicable~~ performance benchmarks, accountability measures, and progress rewards based on the recommendations from the dental access working group.

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MinnesotaCare, including persons served under fee-for-service and persons receiving services through managed care and county-based purchasing plans.

(b) The dental administrator must provide administrative services, including but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and reviews of medical necessity for dental services;

(4) dental claims processing;

(5) coordination of dental care with other services;

(6) management of fraud and abuse;

(7) monitoring access to dental services;

(8) performance measurement;

(9) quality improvement and evaluation; and

(10) management of third-party liability requirements.

~~(c) Dental administrator payments to contracted dental providers must be at the rates established under sections 256B.76 and 256L.11.~~

~~(d)~~ (c) Recipients must be given a choice of dental provider, including any provider who agrees to provider participation requirements and payment rates established by the commissioner and dental administrator. The dental administrator must comply with the network adequacy and geographic access requirements that apply to managed care and county-based purchasing plans for dental services under section 62K.14.

~~(e)~~ (d) The contract with the dental administrator must include a provision that states that if the dental administrator fails to meet, by calendar year ~~2029~~ 2032, a performance benchmark under which at least 55 percent of children and adults who were continuously enrolled for at least 11 months in either medical assistance or MinnesotaCare received at least one dental visit during the calendar year, the contract must be terminated and the commissioner must enter into a contract with a new dental administrator as soon as practicable.

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~~(f) The commissioner shall implement this subdivision in consultation with representatives of providers who provide dental services to patients enrolled in medical assistance or MinnesotaCare, including but not limited to providers serving primarily low-income and socioeconomically complex populations, and with representatives of managed care plans and county-based purchasing plans.~~

Sec. 7. Minnesota Statutes 2024, section 256B.04, subdivision 12, is amended to read:

Subd. 12. **Limitation on services.** (a) The commissioner shall place limits on the types of services covered by medical assistance, the frequency with which the same or similar services may be covered by medical assistance for an individual recipient, and the amount paid for each covered service. The state agency shall promulgate rules establishing maximum reimbursement rates for emergency and nonemergency transportation.

The rules shall provide:

(1) an opportunity for all recognized transportation providers to be reimbursed for nonemergency transportation consistent with the maximum rates established by the agency; and

(2) reimbursement of public and private nonprofit providers serving the population with a disability generally at reasonable maximum rates that reflect the cost of providing the service regardless of the fare that might be charged by the provider for similar services to individuals other than those receiving medical assistance or medical care under this chapter. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(b) The commissioner shall encourage providers reimbursed under this chapter to coordinate their operation with similar services that are operating in the same community. To the extent practicable, the commissioner shall encourage eligible individuals to utilize less expensive providers capable of serving their needs. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective on January 1, 1981, "recognized provider of transportation services" means an operator of special transportation service as defined in section 174.29 that has been issued a current certificate of compliance with operating standards of the commissioner of transportation or, if those standards do not apply to the operator, that the agency finds is able to provide the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized transportation provider" includes an operator of special transportation service that the agency finds is able to provide the required transportation in a safe and reliable manner. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(d) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, the commissioner shall place limits on the types of services covered by medical assistance, the frequency with which the same or similar services may

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~~(f)~~ (e) The commissioner shall implement this subdivision in consultation with representatives of providers who provide dental services to patients enrolled in medical assistance or MinnesotaCare, including but not limited to providers serving primarily low-income and socioeconomically complex populations, and with representatives of managed care plans and county-based purchasing plans.

be covered by medical assistance for an individual recipient, and the amount paid for each covered service.

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

Sec. 8. Minnesota Statutes 2024, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies;

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems; and

(ix) allergen-reducing products as described in section 256B.0625, subdivision 67, paragraph (c) or (d);

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements;

(6) drugs; and

(7) quitline services as described in section 256B.0625, subdivision 68, paragraph (c).

This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(b) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, when determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C to provide items under the medical assistance program, including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies;

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment; and

(viii) electronic diagnostic, therapeutic, and life-support systems;

(5) nonemergency medical transportation; and

(6) drugs.

~~(b)~~ (c) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

~~(c)~~ (d) The commissioner may not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for special transportation services or incontinence products and related supplies. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(e) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, the commissioner must not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for incontinence products and related supplies.

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

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Sec. 9. Minnesota Statutes 2024, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telehealth services.** (a) Medical assistance covers medically necessary services and consultations delivered by a health care provider through telehealth in the same manner as if the service or consultation was delivered through in-person contact. Services or consultations delivered through telehealth shall be paid at the full allowable rate.

(b) The commissioner may establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service through telehealth. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide through telehealth;

(2) has written policies and procedures specific to services delivered through telehealth that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the service is delivered through telehealth;

(4) has established protocols addressing how and when to discontinue telehealth services; and

(5) has an established quality assurance process related to delivering services through telehealth.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service delivered through telehealth to a medical assistance enrollee. Health care service records for services delivered through telehealth must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service delivered through telehealth;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the health care provider's basis for determining that telehealth is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission used to deliver the service through telehealth and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's consultation with another physician through telehealth, the written opinion from the consulting physician providing the telehealth consultation; and

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Sec. 5. Minnesota Statutes 2024, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telehealth services.** (a) Medical assistance covers medically necessary services and consultations delivered by a health care provider through telehealth in the same manner as if the service or consultation was delivered through in-person contact. Services or consultations delivered through telehealth shall be paid at the full allowable rate.

(b) The commissioner may establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service through telehealth. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide through telehealth;

(2) has written policies and procedures specific to services delivered through telehealth that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the service is delivered through telehealth;

(4) has established protocols addressing how and when to discontinue telehealth services; and

(5) has an established quality assurance process related to delivering services through telehealth.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service delivered through telehealth to a medical assistance enrollee. Health care service records for services delivered through telehealth must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service delivered through telehealth;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the health care provider's basis for determining that telehealth is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission used to deliver the service through telehealth and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's consultation with another physician through telehealth, the written opinion from the consulting physician providing the telehealth consultation; and

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(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) Telehealth visits provided through audio and visual communication or accessible video-based platforms may be used to satisfy the face-to-face requirement for reimbursement under the payment methods that apply to a federally qualified health center, rural health clinic, Indian health service, 638 tribal clinic, and certified community behavioral health clinic, if the service would have otherwise qualified for payment if performed in person.

(e) For purposes of this subdivision, unless otherwise covered under this chapter:

(1) "telehealth" means the delivery of health care services or consultations using real-time two-way interactive audio and visual communication or accessible telehealth video-based platforms to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes: the application of secure video conferencing consisting of a real-time, full-motion synchronized video; store-and-forward technology; and synchronous interactions, between a patient located at an originating site and a health care provider located at a distant site. Telehealth does not include communication between health care providers, or between a health care provider and a patient that consists solely of an audio-only communication, email, or facsimile transmission or as specified by law, except that between July 1, 2025, and July 1, 2028, telehealth includes communication between a health care provider and a patient that solely consists of audio-only communication;

(2) "health care provider" means a health care provider as defined under section 62A.673; a community paramedic as defined under section 144E.001, subdivision 5f; a community health worker who meets the criteria under subdivision 49, paragraph (a); a mental health certified peer specialist under section 245I.04, subdivision 10; a mental health certified family peer specialist under section 245I.04, subdivision 12; a mental health rehabilitation worker under section 245I.04, subdivision 14; a mental health behavioral aide under section 245I.04, subdivision 16; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; or a recovery peer under section 245G.11, subdivision 8; and

(3) "originating site," "distant site," and "store-and-forward technology" have the meanings given in section 62A.673, subdivision 2.

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

Sec. 10. 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.

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(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) Telehealth visits provided through audio and visual communication or accessible video-based platforms may be used to satisfy the face-to-face requirement for reimbursement under the payment methods that apply to a federally qualified health center, rural health clinic, Indian health service, 638 tribal clinic, and certified community behavioral health clinic, if the service would have otherwise qualified for payment if performed in person.

(e) For purposes of this subdivision, unless otherwise covered under this chapter:

(1) "telehealth" means the delivery of health care services or consultations using real-time two-way interactive audio and visual communication or accessible telehealth video-based platforms to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes: the application of secure video conferencing consisting of a real-time, full-motion synchronized video; store-and-forward technology; and synchronous interactions, between a patient located at an originating site and a health care provider located at a distant site. Telehealth does not include communication between health care providers, or between a health care provider and a patient that consists solely of an audio-only communication, email, or facsimile transmission or as specified by law, except that from July 1, 2025, to July 1, 2028, telehealth includes communication between a health care provider and a patient that solely consists of audio-only communication;

(2) "health care provider" means a health care provider as defined under section 62A.673; a community paramedic as defined under section 144E.001, subdivision 5f; a community health worker who meets the criteria under subdivision 49, paragraph (a); a mental health certified peer specialist under section 245I.04, subdivision 10; a mental health certified family peer specialist under section 245I.04, subdivision 12; a mental health rehabilitation worker under section 245I.04, subdivision 14; a mental health behavioral aide under section 245I.04, subdivision 16; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; or a recovery peer under section 245G.11, subdivision 8; and

(3) "originating site," "distant site," and "store-and-forward technology" have the meanings given in section 62A.673, subdivision 2.

EFFECTIVE DATE. This section is effective July 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

(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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(g) Effective July 1, 2026, for medical fee-for-service and January 1, 2027, for prepaid medical assistance, 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 program beneficiaries to obtain covered medical services; and

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

~~(g)~~ (h) 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 ~~(f)~~ (n), clauses (4), (5), (6), and (7). This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(h)~~ (i) 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)~~ (j) 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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(k) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, 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 administrator.

~~(j)~~ (l) 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)~~ (m) 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)~~ (n) 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)~~ (o) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph ~~(l)~~ (n) according to paragraphs ~~(p) and (q)~~ (r) to (t) 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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(n)~~ (p) 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)~~ (q) 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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(p)~~ (r) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph ~~(k)~~ (m), 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 and $2.40 per mile for protected transport; and

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(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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(s) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (m), not the type of vehicle used to provide the service.

~~(q)~~ (t) 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 paragraph ~~(p)~~ (r), 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)~~ (r), 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)~~ (r), clauses (1) to (7). This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(r)~~ (u) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs ~~(p) and (q)~~ (r) to (t), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(s)~~ (v) 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)~~ (n) from Minnesota Rules, part 9505.0445, item R, subitem (2).

~~(t)~~ (w) 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)~~ (r) 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. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

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

Sec. 11. Minnesota Statutes 2024, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria.

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Sec. 6. Minnesota Statutes 2024, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria.

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Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

(b) Effective for services provided on or after July 1, 2016, medical assistance payment rates for ambulance services identified in this paragraph are increased by five percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2017, shall be increased to reflect this rate increase. The increased rate described in this paragraph applies to ambulance service providers whose base of operations as defined in section 144E.10 is located:

(1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

(2) within a municipality with a population of less than 1,000.

(c) Effective for services provided statewide on or after January 1, 2026, medical assistance payment rates for ambulance services are increased by 13.68 percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2026, must be increased to reflect this rate increase.

~~(c)~~ (d) 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 (a) 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.

~~(d)~~ (e) Managed care plans and county-based purchasing plans must provide a fuel adjustment for ambulance services rates when fuel exceeds $3 per gallon. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that

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Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

(b) Effective for services provided on or after July 1, 2016, medical assistance payment rates for ambulance services identified in this paragraph are increased by five percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2017, shall be increased to reflect this rate increase. The increased rate described in this paragraph applies to ambulance service providers whose base of operations as defined in section 144E.10 is located:

(1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

(2) within a municipality with a population of less than 1,000.

(c) Effective for services provided statewide on or after January 1, 2026, medical assistance payment rates for ambulance services are increased by 15 percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2026, must be increased to reflect this rate increase.

(d) Effective for services provided on or after January 1, 2026, medical assistance payment rates for ambulance services identified in this paragraph are increased by ten percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2026, must be increased to reflect this rate increase. The increased rate described in this paragraph applies to ambulance service providers whose base of operations, as defined in section 144E.001, is located:

(1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

(2) within a municipality with a population of less than 1,000.

~~(c)~~ (e) 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 (a) 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.

~~(d)~~ (f) Managed care plans and county-based purchasing plans must provide a fuel adjustment for ambulance services rates when fuel exceeds $3 per gallon. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that

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contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph. This paragraph expires if federal approval is not received for this paragraph at any time.

Sec. 12. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 18i. **Administration of nonemergency medical transportation.** Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, the commissioner must contract either statewide or regionally for the administration of the nonemergency medical transportation program in compliance with the provisions of this chapter. The contract must include the administration of the nonemergency medical transportation benefit for those enrolled in managed care as described in section 256B.69.

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

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contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph. This paragraph expires if federal approval is not received for this paragraph at any time.

Sec. 7. Minnesota Statutes 2024, section 256B.0625, subdivision 25c, is amended to read:

Subd. 25c. **Applicability of utilization review provisions.** (a) Effective January 1, 2026, the following provisions of chapter 62M apply to the commissioner when delivering services under chapters 256B and 256L: 62M.02, subdivisions 1 to 5, 7 to 12, 13, 14 to 18, and 21; 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions 1 to 3; 62M.07; 62M.072; 62M.09; 62M.10; 62M.12; and 62M.17, subdivision 2~~; and 62M.18~~.

(b) By April 1, 2026, and each April 1 thereafter, managed care plans and county-based purchasing plans when the plan is providing coverage to enrollees under chapter 256B or 256L, and the commissioner when delivering services under chapters 256B and 256L, must post on the entity's public website the following data for the immediately preceding calendar year for each health plan or program:

(1) the number of prior authorization requests for which an authorization was issued;

(2) the number of prior authorization requests for which an adverse determination was issued and sorted by:

(i) health care service;

(ii) whether the adverse determination was appealed; and

(iii) whether the adverse determination was upheld or reversed on appeal;

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Sec. 13. Minnesota Statutes 2024, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. An FQHC that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions

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(3) the number of prior authorization requests that were submitted electronically and not by facsimile or email or other method pursuant to section 62J.497; and

(4) the reasons for prior authorization denial, including but not limited to:

(i) the patient did not meet prior authorization criteria;

(ii) the provider submitted incomplete information to the utilization review organization;

(iii) a change in treatment program; and

(iv) the patient is no longer covered by the plan or program.

(c) All information posted under paragraph (b) must be written in easily understandable language.

Sec. 8. Minnesota Statutes 2024, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. An FQHC that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions

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applicable to the same service provided by health care providers that are not FQHCs or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring an FQHC or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, through December 31, 2020, each FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l), or, upon federal approval, for FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act, as provided under paragraph (k).

(h) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

(i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner. the commissioner shall determine the most feasible method for paying claims from the following options:

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applicable to the same service provided by health care providers that are not FQHCs or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring an FQHC or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, through December 31, 2020, each FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l), or, upon federal approval, for FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act, as provided under paragraph (k).

(h) For purposes of this section, "nonprofit community clinic" is a clinic that:

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(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

(i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner. the commissioner shall determine the most feasible method for paying claims from the following options:

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(1) FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) FQHCs and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

(j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

(k) The commissioner shall establish an encounter payment rate that is equivalent to the all inclusive rate (AIR) payment established by the Indian Health Service and published in the Federal Register. The encounter rate must be updated annually and must reflect the changes in the AIR established by the Indian Health Service each calendar year. FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act may elect to be paid: (1) at the encounter rate established under this paragraph; (2) under the alternative payment methodology described in paragraph (l); or (3) under the federally required prospective payment system described in paragraph (f). FQHCs that elect to be paid at the encounter rate established under this paragraph must continue to meet all state and federal requirements related to FQHCs and urban Indian organizations, and must maintain their statuses as FQHCs and urban Indian organizations.

(l) All claims for payment of clinic services provided by FQHCs and rural health clinics, that have elected to be paid under this paragraph, shall be paid by the commissioner according to the following requirements:

(1) the commissioner shall establish a single medical and single dental organization encounter rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization encounter rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct

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(1) FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) FQHCs and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

(j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

(k) The commissioner shall establish an encounter payment rate that is equivalent to the all inclusive rate (AIR) payment established by the Indian Health Service and published in the Federal Register. The encounter rate must be updated annually and must reflect the changes in the AIR established by the Indian Health Service each calendar year. FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act may elect to be paid: (1) at the encounter rate established under this paragraph; (2) under the alternative payment methodology described in paragraph (l); or (3) under the federally required prospective payment system described in paragraph (f). FQHCs that elect to be paid at the encounter rate established under this paragraph must continue to meet all state and federal requirements related to FQHCs and urban Indian organizations, and must maintain their statuses as FQHCs and urban Indian organizations.

(l) All claims for payment of clinic services provided by FQHCs and rural health clinics, that have elected to be paid under this paragraph, shall be paid by the commissioner according to the following requirements:

(1) the commissioner shall establish a single medical and single dental organization encounter rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization encounter rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct

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patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social services and administrative costs;

(ii) retail pharmacy;

(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fundraising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

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patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social services and administrative costs;

(ii) retail pharmacy;

(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fundraising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

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(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year. Years in which organizational cost or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency shall not be used as part of a base year when the base year includes more than one year. The commissioner may use the Medicare cost reports of a year unaffected by a pandemic, disease, or other public health emergency, or previous two consecutive years, inflated to the base year as established under item (iv);

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization encounter rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization encounter rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate currently received by the FQHC or rural health clinic;

(10) for FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established

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(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year. Years in which organizational cost or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency shall not be used as part of a base year when the base year includes more than one year. The commissioner may use the Medicare cost reports of a year unaffected by a pandemic, disease, or other public health emergency, or previous two consecutive years, inflated to the base year as established under item (iv);

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization encounter rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization encounter rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate currently received by the FQHC or rural health clinic;

(10) for FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established

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under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rates;

(13) the commissioner, when establishing organization encounter rates under this section for FQHCs and rural health clinics resulting from a merger of existing clinics or the acquisition of an existing clinic by another existing clinic, must use the combined costs and caseloads from the clinics participating in the merger or acquisition to set the encounter rate for the new clinic organization resulting from the merger or acquisition. The scope of services for the newly formed clinic must be inclusive of the scope of services of the clinics participating in the merger or acquisition;

~~(13)~~ (14) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

~~(14)~~ (15) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

(m) Effective July 1, 2023, an enrolled Indian health service facility or a Tribal health center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC. Requirements that otherwise apply to an FQHC covered in this subdivision do not apply to a Tribal FQHC enrolled under this paragraph, except that any requirements necessary to comply with federal regulations do apply to a Tribal FQHC. The commissioner shall establish an alternative payment method for a Tribal FQHC enrolled under this paragraph that uses

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under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rates;

(13) the commissioner, when establishing organization encounter rates under this section for FQHCs and rural health clinics resulting from a merger of existing clinics or the acquisition of an existing clinic by another existing clinic, must use the combined costs and caseloads from the clinics participating in the merger or acquisition to set the encounter rate for the new clinic organization resulting from the merger or acquisition. The scope of services for the newly formed clinic must be inclusive of the scope of services of the clinics participating in the merger or acquisition;

~~(13)~~ (14) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

~~(14)~~ (15) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

(m) Effective July 1, 2023, an enrolled Indian health service facility or a Tribal health center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC. Requirements that otherwise apply to an FQHC covered in this subdivision do not apply to a Tribal FQHC enrolled under this paragraph, except that any requirements necessary to comply with federal regulations do apply to a Tribal FQHC. The commissioner shall establish an alternative payment method for a Tribal FQHC enrolled under this paragraph that uses

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the same method and rates applicable to a Tribal facility or health center that does not enroll as a Tribal FQHC.

(n) FQHC reimbursement for mental health targeted case management services is limited to:

(1) only those services described under subdivision 20 and provided in accordance with contracts executed with counties authorized to subcontract for mental health targeted case management services; and

(2) an FQHC's actual incurred costs as separately reported on the cost report submitted to the Centers for Medicare and Medicaid Services and further identified in reports submitted to the commissioner.

(o) Counties contracting with FQHCs for mental health targeted case management remain responsible for the nonfederal share of the cost of the provided mental health targeted case management services. The commissioner must bill each county for the nonfederal share of the mental health targeted case management costs as reported by the FQHC.

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

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the same method and rates applicable to a Tribal facility or health center that does not enroll as a Tribal FQHC.

(n) FQHC reimbursement for mental health targeted case management services is limited to:

(1) only those services described under section 256B.0625, subdivision 20, and provided in accordance with contracts executed with counties authorized to subcontract for mental health targeted case management services; and

(2) an FQHC's actual incurred costs as separately reported on the cost report submitted to the Centers for Medicare and Medicaid Services and further identified in reports submitted to the commissioner.

(o) Counties contracting with FQHCs for mental health targeted case management remain responsible for the nonfederal share of the cost of the provided mental health targeted case management services. The commissioner must bill each county for the nonfederal share of the mental health targeted case management costs as reported by the FQHC.

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

Sec. 9. Minnesota Statutes 2024, section 256B.0625, subdivision 54, is amended to read:

Subd. 54. **Services provided in birth centers.** (a) Medical assistance covers services provided in a licensed birth center by a licensed health professional if the service would otherwise be covered if provided in a hospital.

(b) Facility services provided by a birth center shall be paid at the lower of billed charges or ~~70~~ 100 percent of the ~~statewide average for a facility payment rate made to a hospital~~ hospital facility fee cost trended to current for an uncomplicated vaginal birth as determined using the most recent calendar year for which complete claims data is available. If a recipient is transported from a birth center to a hospital prior to the delivery, the payment for facility services to the birth center shall be the lower of billed charges or ~~15~~ 100 percent of the ~~average~~ hospital facility ~~payment made to a hospital for the services provided~~ fee cost trended to current for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data is available.

(c) ~~Nursery care~~ Facility services provided to a newborn by a birth center shall be paid the lower of billed charges or ~~70~~ 100 percent of ~~the statewide average for a payment rate paid to a hospital for nursery care as determined by using the most recent calendar year for which complete claims data is available~~ the hospital facility fee for a normal newborn as determined using the most recent calendar year for which complete claims data is available, cost trended to current.

(d) Professional services provided by traditional midwives licensed under chapter 147D shall be paid at the lower of billed charges or 100 percent of the rate paid to a physician performing the same services. If a recipient is transported from a birth center to a hospital prior to the delivery, a licensed traditional midwife who does not perform the delivery may

not bill for any delivery services. Services are not covered if provided by an unlicensed traditional midwife.

(e) Licensed health professionals working in licensed birth centers shall be reimbursed for the full range of maternity care and newborn care services within their scope of practice, regardless of place of service. The commissioner shall review current birth center reimbursement and, in consultation with birth centers currently licensed in the state, develop revisions to current payment practices in order to ensure reimbursement for the full range of maternity care and newborn care services, including but not limited to:

(1) professional services for intrapartum care when a recipient is transferred from a birth center to a hospital prior to delivery;

(2) professional services billed with a home place of service code by a licensed health professional within their scope of practice;

(3) professional services when a licensed health professional provides any Minnesota-mandated newborn screening, including but not limited to the newborn metabolic screen, CCHD screening, hearing screen, or any other medically necessary newborn screening, test, or assessment; and

(4) telehealth services provided by any licensed health professional working in a birth center.

(f) Managed care organizations and county-based purchasing plans contracted to provide medical assistance coverage under section 256B.69 shall reimburse licensed birth centers and licensed health professionals working in licensed birth centers for the full range of maternity care services within their scope of practice, regardless of place of service, as determined in paragraph (e) at no less than the medical assistance fee for service fee schedule for the year in which the service is provided.

~~(e)~~ (g) The commissioner shall apply for any necessary waivers from the Centers for Medicare and Medicaid Services to allow birth centers and birth center providers to be reimbursed.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 54a. **Home birth.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "birth services" means prenatal, labor, birth, and postpartum services;

(2) "eligible provider" means a licensed or certified health care professional eligible for reimbursement under the medical assistance program; and

(3) "low-risk patient for birth services" means a person undergoing a normal, uncomplicated prenatal course as determined by documentation of adequate prenatal care who anticipates a normal, uncomplicated labor and birth, as defined by reasonable and generally accepted criteria adopted by professional groups for maternal, fetal, and neonatal health care.

(b) Medical assistance covers birth services provided at home when the following conditions are met:

(1) the birth services are provided by an eligible provider whose scope of practice and experience includes home birth;

(2) the recipient is a low-risk patient for birth services; and

(3) the recipient has a plan of care that includes:

(i) a consent form detailing the risks and benefits of home birth signed by the recipient;

(ii) sufficient visits, test results, and follow-up consultations as needed to establish that the recipient is a low-risk patient for birth services; and

(iii) a plan for transfer to a hospital as needed.

(c) Services provided under this subdivision by an eligible provider must be paid at a rate at least equal to 100 percent of the rate paid to a physician performing the same services. An eligible provider who does not perform the delivery must not bill for any delivery services.

(d) Supplies used for birth services under this subdivision must be paid at 70 percent of the statewide average for a facility payment rate made to a hospital for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data are available. If a recipient is transported from a home to a hospital prior to the delivery, the payment for the supplies used for birth services under this subdivision must be the lower of billed charges or 15 percent of the statewide average for a facility payment rate made to a hospital for the services provided for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data are available.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. Minnesota Statutes 2024, section 256B.0757, subdivision 5, is amended to read:

Subd. 5. **Payments.** (a) The commissioner shall make payments to each designated provider for the provision of health home services described in subdivision 3 to each eligible

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Sec. 14. Minnesota Statutes 2024, section 256B.1973, subdivision 5, is amended to read:

Subd. 5. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment arrangement that is a state-directed fee schedule

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individual under subdivision 2 that selects the health home as a provider. This paragraph expires on the date that paragraph (b) becomes effective.

(b) Effective January 1, 2028, or upon federal approval, whichever is later, the commissioner shall make payments to each designated provider for the provision of health home services described in subdivision 3, except for behavioral health services, to each eligible individual under subdivision 2 who selects the health home as a provider.

Sec. 12. Minnesota Statutes 2024, section 256B.0757, is amended by adding a subdivision to read:

Subd. 5a. **Payments for behavioral health home services.** (a) Notwithstanding subdivision 5, the commissioner must implement a single statewide reimbursement rate for behavioral health home services under this section. The rate must be no less than $425 per member per month. The commissioner must adjust the reimbursement rate for behavioral health home services annually according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year.

(b) The commissioner must review and update the behavioral health home services rate under paragraph (a) at least every four years. The updated rate must account for the average hours required for behavioral health home team members spent providing services and the Department of Labor prevailing wage for required behavioral health home team members. The updated rate must ensure that behavioral health home services rates are sufficient to allow providers to meet required certifications, training, and practice transformation standards; staff qualification requirements; and service delivery standards.

(c) Managed care plans and county-based purchasing plans must reimburse providers at an amount that is at least equal to the fee-for-service rate for services under this subdivision. The commissioner must monitor the effect of this rate increase on enrollee access to services under this subdivision. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this paragraph. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph.

(d) This subdivision is effective January 1, 2028, or upon federal approval, whichever is later.

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requirement, the commissioner shall determine a uniform adjustment factor to be applied to each claim submitted by an eligible provider to a health plan. The uniform adjustment factor shall be determined using the average commercial payer rate or using another method acceptable to the Centers for Medicare and Medicaid Services if the average commercial payer rate is not approved, minus the amount necessary for the plan to satisfy tax liabilities under sections 256.9657 and 297I.05 attributable to the directed payment arrangement. The commissioner shall ensure that the application of the uniform adjustment factor maximizes the allowable directed payments and does not result in payments exceeding federal limits, and may use an annual settle-up process. The directed payment ~~shall~~ may be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(b) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that the eligible provider receives the entire permissible value of the federally approved directed payment arrangement. If federal approval of a directed payment arrangement under this subdivision is retroactive, the commissioner shall make a onetime pro rata increase to the uniform adjustment factor and the initial payments in order to include claims submitted between the retroactive federal approval date and the period captured by the initial payments.

Sec. 15. Minnesota Statutes 2024, section 256B.1973, is amended by adding a subdivision to read:

Subd. 9. **Interaction with other directed payments.** An eligible provider under subdivision 3 may participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both. A provider participating in the hospital directed payment program must not receive a directed payment under this section for any provider classes paid via the hospital directed payment program. A hospital subject to this section must notify the commissioner in writing no later than 30 days after enactment of this subdivision of its intention to participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both. The election under this subdivision is a onetime election, except that if an eligible provider elects to participate in the hospital directed payment program, and the hospital directed payment program expires, then the eligible provider may thereafter elect to participate in the directed payment under this section.

EFFECTIVE DATE. (a) This section is effective on the later of January 1, 2026, or federal approval of all of the following:

(1) the waiver for the assessment required under Minnesota Statutes, section 256.9657, subdivision 2b; and

(2) the amendments in this act to Minnesota Statutes, section 256B.1974.

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Sec. 13. Minnesota Statutes 2024, section 256B.1973, is amended by adding a subdivision to read:

Subd. 9. **Interaction with other directed payments.** An eligible provider under subdivision 3 may participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both. A provider participating in the hospital directed payment program must not receive a directed payment under this section for any provider classes paid via the hospital directed payment program. A hospital subject to this section must notify the commissioner in writing no later than 30 days after enactment of this subdivision of its intention to participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both. The election under this subdivision is a onetime election, except that if an eligible provider elects to participate in the hospital directed payment program, and the hospital directed payment program expires, then the eligible provider may thereafter elect to participate in the directed payment program under this section.

EFFECTIVE DATE. (a) This section is effective on the later of January 1, 2026, or federal approval of all of the following:

(1) this section;

(2) the amendments in this act to add Minnesota Statutes, section 256.9657, subdivision 2b; and

(3) the amendments in this act to Minnesota Statutes, section 256B.1974.

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(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 16. **[256B.1974] HOSPITAL DIRECTED PAYMENT PROGRAM.**

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

(b) "Health plan" means a managed care plan or county-based purchasing plan that is under contract with the commissioner to deliver services to medical assistance enrollees under section 256B.69.

(c) "Eligible hospital" has the meaning given in section 256.9657, subdivision 2b, paragraph (a), clause (1).

Subd. 2. **Required conditions for program.** The hospital directed payment program is contingent on the satisfaction of all requirements necessary for the collection of an assessment under section 256.9657, and must conform with the requirements for permissible directed managed care organization expenditures under section 256B.6928, subdivision 5.

Subd. 3. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment program that is a state-directed fee schedule requirement that includes a quarterly payment amount to be submitted by each health plan to each eligible hospital, the commissioner must determine the quarterly payment amount using the statewide average commercial payer rate, or using another method acceptable to the Centers for Medicare and Medicaid Services if the statewide average commercial payer rate is not approved. The commissioner must ensure that the application of the quarterly payment amounts maximizes the amount generated by the hospital assessment in section 256.9657, subdivision 2b, for allowable directed payments and does not result in payments exceeding federal limits.

(b) The commissioner must use an annual settle-up process that occurs within the time period allowed for medical assistance managed care claims adjustments.

(c) On and after January 1, 2028, if the federal regulations set forth in Code of Federal Regulations, title 42, parts 430, 438, and 457, remain effective, the hospital directed payment program may be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(d) For each federally approved directed payment program that is a state-directed fee schedule requirement, the commissioner must develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that eligible hospitals receive the entire permissible value of the federally approved directed payment.

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(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 14. **[256B.1974] HOSPITAL DIRECTED PAYMENT PROGRAM.**

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

(b) "Health plan" means a managed care plan or county-based purchasing plan that is under contract with the commissioner to deliver services to medical assistance enrollees under section 256B.69.

(c) "Hospital" means a hospital licensed under section 144.50.

Subd. 2. **Required conditions for program.** The hospital directed payment program is contingent on the satisfaction of all requirements necessary for the collection of an assessment under section 256.9657, and must conform with the requirements for permissible directed managed care organization expenditures under section 256B.6928, subdivision 5.

Subd. 3. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment program that is a state-directed fee schedule requirement that includes a quarterly payment amount to be submitted by each health plan to each hospital, the commissioner must determine the quarterly payment amount using the average commercial payer rate, or using another method acceptable to the Centers for Medicare and Medicaid Services if the average commercial payer rate is not approved. The commissioner must ensure that the application of the quarterly payment amounts maximizes the amount generated by the hospital assessment in section 256.9657, subdivision 2b, for allowable directed payments and does not result in payments exceeding federal limits.

(b) The commissioner must use an annual settle-up process that occurs within the time period allowed for medical assistance managed care claims adjustments.

(c) On and after January 1, 2028, if the federal regulations set forth in Code of Federal Regulations, title 42, parts 430, 438, and 457, remain effective, the hospital directed payment program must be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(d) For each federally approved directed payment program that is a state-directed fee schedule requirement, the commissioner must develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that hospitals receive the entire permissible value of the federally approved directed payment. If federal approval of a directed payment under this subdivision is retroactive, the commissioner must make a onetime pro rata increase to the quarterly payment amount and the initial payments to include

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(e) Directed payments under this section must only be used to supplement, and not supplant, medical assistance reimbursement to eligible hospitals. The directed payment program must not modify, reduce, or offset the medical assistance payment rates determined for each eligible hospital as required by section 256.969.

(f) The commissioner must require health plans to make quarterly directed payments according to this section.

(g) Health plans must make quarterly directed payments using electronic funds transfers, if the eligible hospital provides the information necessary to process such transfers, and in accordance with directions provided by the commissioner. Health plans must make quarterly directed payments:

(1) for the first two quarters for which such payments are due, within 30 calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section; and

(2) for all subsequent quarters, within ten calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section.

(h) The commissioner of human services must publish on the Department of Human Services website, on a quarterly basis, the dates that the health plans completed their required quarterly payments under this section.

(i) Payments to health plans that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this section must not be reduced as a result of this section.

(j) The commissioner must publish all directed payments resulting from this section owed to each eligible hospital from each health plan on the Department of Human Services website for at least two years. All calculations and reports must be posted no later than the first day of the quarter for which the payments are to be issued.

(k) By December 1 each year, the commissioner must notify each eligible hospital of any changes to the payment methodologies in this section, including but not limited to changes in the directed payment rates, the aggregate directed payment amount for all eligible hospitals, and the eligible hospital's directed payment amount for the upcoming calendar year.

(l) The commissioner must distribute payments required under this section for each eligible hospital within 30 days of a quarterly assessment under section 256.9657, subdivision 2b, being received. The commissioner must pay the directed payments to health plans under contract no later than January 1, April 1, July 1, and October 1 each year.

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claims submitted between the retroactive federal approval date and the period captured by the initial payments.

(e) Directed payments under this section must only be used to supplement, and not supplant, medical assistance reimbursement to hospitals. The directed payment program must not modify, reduce, or offset the medical assistance payment rates determined for each hospital as required by section 256.969.

(f) The commissioner must require health plans to make quarterly directed payments according to this section.

(g) Health plans must make quarterly directed payments using electronic funds transfers, if the hospital provides the information necessary to process such transfers, and in accordance with directions provided by the commissioner. Health plans must make quarterly directed payments:

(1) for the first two quarters for which such payments are due, within 30 calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section; and

(2) for all subsequent quarters, within ten calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section.

(h) The commissioner must publish on the Department of Human Services' website, on a quarterly basis, the dates that the health plans completed their required quarterly payments under this section.

(i) Payments to health plans that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this section must not be reduced as a result of this section.

(j) The commissioner must publish all directed payments owed to each hospital from each health plan on the department's website for at least two years. All calculations and reports must be posted no later than the first day of the quarter for which the payments are to be issued.

(k) By December 1 each year, the commissioner must notify each hospital of any changes to the payment methodologies in this section, including but not limited to changes in the directed payment rates, the aggregate directed payment amount for all hospitals, and the hospital's directed payment amount for the upcoming calendar year.

(l) The commissioner must distribute payments required under this section for each hospital within 30 days of a quarterly assessment under section 256.9657, subdivision 2b, being received. The commissioner must pay the directed payments to health plans under contract no later than January 1, April 1, July 1, and October 1 each year.

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(m) A hospital is not entitled to payments under this section until it is an eligible hospital. An eligible hospital that has merged with another hospital must have its payments under this section revised at the start of the first full fiscal year after the merger is complete. A closed eligible hospital is entitled to the payments under this section for services provided through the final date of operations.

Subd. 4. **Health plan duties; submission of claims.** Each health plan must submit to the commissioner, in accordance with its contract with the commissioner to serve as a managed care organization in medical assistance, payment information for each claim paid to an eligible hospital for services provided to a medical assistance enrollee. Health plans must allow each eligible hospital to review the health plan's own paid claims detail to enable proper validation that the medical assistance managed care claims volume and content is consistent with the eligible hospital's internal records. To support the validation process for the directed payment program, health plans must permit the commissioner to share inpatient and outpatient claims-level details with eligible hospitals identifying only those claims where the prepaid medical assistance program under section 256B.69 is the payer source. Eligible hospitals must provide notice of discrepancies in claims paid to the commissioner in a form determined by the commissioner. The commissioner is authorized to determine the final disposition of the validation process for disputed claims.

Subd. 5. **Health plan duties; directed payment add-on.** (a) Each health plan must make, in accordance with its contract with the commissioner to serve as a managed care organization in medical assistance, a directed payment to each eligible hospital. The amount of the directed payment to the eligible hospital must be equal to the payment amounts the plan received from the commissioner for the hospital.

(b) Health plans are prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with an eligible hospital in a manner that directly or indirectly takes into account a directed payment that a hospital receives under this section;

(2) unnecessarily delaying a directed payment to an eligible hospital; or

(3) recouping or offsetting a directed payment for any reason, except as expressly authorized by the commissioner.

Subd. 6. **Hospital duties; quarterly supplemental directed payment add-on.** (a) An eligible hospital receiving a directed payment under this section is prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with a managed care organization in a manner that directly or indirectly takes into account a directed payment that an eligible hospital receives under this section; or

(2) directly passing on the cost of an assessment to patients or nonmedical assistance payers, including as a fee or rate increase.

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(m) A hospital is not entitled to payments under this section until the start of the first full fiscal year it is an eligible hospital. A hospital that has merged with another hospital must have its payments under this section revised at the start of the first full fiscal year after the merger is complete. A closed hospital is entitled to the payments under this section for services provided through the final date of operations.

Subd. 4. **Health plan duties; submission of claims.** Each health plan must submit to the commissioner, in accordance with its contract with the commissioner to serve as a managed care organization in medical assistance, payment information for each claim paid to a hospital for services provided to a medical assistance enrollee. Health plans must allow each hospital to review the health plan's own paid claims detail to enable proper validation that the medical assistance managed care claims volume and content is consistent with the hospital's internal records. To support the validation process for the directed payment program, health plans must permit the commissioner to share inpatient and outpatient claims-level details with hospitals identifying only those claims where the prepaid medical assistance program under section 256B.69 is the payer source. Hospitals must provide notice of discrepancies in claims paid to the commissioner in a form determined by the commissioner. The commissioner is authorized to determine the final disposition of the validation process for disputed claims.

Subd. 5. **Health plan duties; directed payment add-on.** (a) Each health plan must make, in accordance with its contract with the commissioner to serve as a managed care organization in medical assistance, a directed payment to each hospital. The amount of the directed payment to the hospital must be equal to the payment amounts the plan received from the commissioner for the hospital.

(b) Health plans are prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with a hospital in a manner that directly or indirectly takes into account a directed payment that a hospital receives under this section;

(2) unnecessarily delaying a directed payment to a hospital; or

(3) recouping or offsetting a directed payment for any reason, except as expressly authorized by the commissioner.

Subd. 6. **Hospital duties; quarterly supplemental directed payment add-on.** (a) A hospital receiving a directed payment under this section is prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with a managed care organization in a manner that directly or indirectly takes into account a directed payment that a hospital receives under this section; or

(2) directly passing on the cost of an assessment to patients or nonmedical assistance payers, including as a fee or rate increase.

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(b) An eligible hospital that violates this subdivision is prohibited from receiving a directed payment under this section for the remainder of the calendar year. This subdivision does not prohibit an eligible hospital from negotiating with a payer for a rate increase.

(c) Any eligible hospital receiving a directed payment under this section must meet the commissioner's standards for directed payments as described in subdivision 7.

Subd. 7. **State minimum policy goals established.** (a) The effect of the directed payments under this section must align with the state's policy goals for medical assistance enrollees. The directed payments must be used to maintain quality and access to a full range of health care delivery mechanisms for medical assistance enrollees, and specifically provide improvement for one of the following quality measures:

(1) overall well child visit rates;

(2) maternal depression screening rates; or

(3) colon cancer screening rates.

(b) The commissioner, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services a quality measures performance evaluation criteria and methodology to regularly measure access to care and the achievement of state policy goals described in this subdivision.

(c) The quality measures evaluation data, as determined by paragraph (b), must be reported to the Centers for Medicare and Medicaid Services after at least 12 months of directed payments to hospitals.

Subd. 8. **Administrative review.** Before making the payments required under this section, and on at least an annual basis, the commissioner must consult with and provide for review of the payment amounts by a permanent select committee established by the Minnesota Hospital Association. Any data or information reviewed by members of the committee are data not on individuals, as defined in section 13.02. The committee's members may not include any current employee or paid consultant of any hospital.

EFFECTIVE DATE. (a) This section is effective the later of January 1, 2026, or federal approval of all of the following:

(1) the amendments in this act adding Minnesota Statutes, section 256.9657, subdivision 2b; and

(2) the amendments in this act to this section.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

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(b) A hospital that violates this subdivision is prohibited from receiving a directed payment under this section for the remainder of the rate year. This subdivision does not prohibit a hospital from negotiating with a payer for a rate increase.

(c) Any hospital receiving a directed payment under this section must meet the commissioner's standards for directed payments as described in subdivision 7.

Subd. 7. **State minimum policy goals established.** (a) The effect of the directed payments under this section must align with the state's policy goals for medical assistance enrollees. The directed payments must be used to maintain quality and access to a full range of health care delivery mechanisms for medical assistance enrollees, and specifically provide improvement for one of the following quality measures:

(1) overall well child visit rates;

(2) maternal depression screening rates; or

(3) colon cancer screening rates.

(b) The commissioner, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services quality measures performance evaluation criteria and a methodology to regularly measure access to care and the achievement of state policy goals described in this subdivision.

(c) The quality measures evaluation data, as determined by paragraph (b), must be reported to the Centers for Medicare and Medicaid Services after at least 12 months of directed payments to hospitals.

Subd. 8. **Administrative review.** Before making the payments required under this section, and on at least an annual basis, the commissioner must consult with and provide for review of the payment amounts by a permanent select committee established by the Minnesota Hospital Association. Any data or information reviewed by members of the committee are data not on individuals, as defined in section 13.02. The committee's members must not include any current employee or paid consultant of any hospital.

EFFECTIVE DATE. (a) This section is effective the later of January 1, 2026, or federal approval for all of the following:

(1) the amendments in this act to add Minnesota Statutes, section 256.9657, subdivision 2b; and

(2) the amendments in this act to this section.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

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Sec. 17. **[256B.1975] HOSPITAL DIRECTED PAYMENT PROGRAM ACCOUNT.**

Subdivision 1. **Account established; appropriation.** (a) The hospital directed payment program account is created in the special revenue fund in the state treasury.

(b) Money in the account, including interest earned, is annually appropriated to the commissioner for the purposes specified in section 256B.1974.

(c) Transfers from this account to another fund are prohibited, except as necessary to make the payments required under section 256B.1974.

Subd. 2. **Reports to the legislature.** By January 15, 2027, and each January 15 thereafter, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance that details the activities and uses of money in the hospital directed payment program account, including the metrics and outcomes of the policy goals established by section 256B.1974, subdivision 7.

EFFECTIVE DATE. This section is effective on the later of January 1, 2026, or federal approval of the amendments in this act adding Minnesota Statutes, section 256.9657, subdivision 2b. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 18. Minnesota Statutes 2024, section 256B.69, subdivision 3a, is amended to read:

Subd. 3a. **County authority.** (a) The commissioner, when implementing the medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 142F and 145A and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of initial implementation of the prepaid medical assistance program

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Sec. 15. **[256B.1975] HOSPITAL DIRECTED PAYMENT PROGRAM ACCOUNT.**

Subdivision 1. **Account established; appropriation.** (a) The hospital directed payment program account is created in the special revenue fund in the state treasury.

(b) Money in the account, including interest earned, is annually appropriated to the commissioner for the purposes specified in section 256B.1974.

(c) Transfers from this account to another fund are prohibited, except as necessary to make the payments required under section 256B.1974.

Subd. 2. **Reports to the legislature.** By January 15, 2027, and each January 15 thereafter, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance that details the activities and uses of money in the hospital directed payment program account, including the metrics and outcomes of the policy goals established by section 256B.1974, subdivision 7.

EFFECTIVE DATE. This section is effective on the later of January 1, 2026, or federal approval of the amendments in this act to add Minnesota Statutes, section 256.9657, subdivision 2b. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process.

(b) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical assistance enrollees. These requirements must be reasonably related to the performance of health plan functions and within the scope of the medical assistance benefit set. If the county board and the commissioner mutually agree to such requirements, the department shall include such requirements in all health plan contracts governing the prepaid medical assistance program in that county at initial implementation of the program in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

(c) For counties in which a prepaid medical assistance program has not been established, the commissioner shall not implement that program if a county board submits an acceptable and timely preliminary and final proposal under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts a preliminary and final proposal according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment. This paragraph expires upon the effective date of paragraph (d).

(d) For counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts a preliminary and final proposal according to that subdivision. This paragraph is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

~~(d)~~ (e) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all

documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

~~(e)~~ (f) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

~~(f)~~ (g) The commissioner shall not require that contractual disputes between county-based purchasing entities and the commissioner be mediated by a panel that includes a representative of the Minnesota Council of Health Plans.

~~(g)~~ (h) At the request of a county-purchasing entity, the commissioner shall adopt a contract reprocurement or renewal schedule under which all counties included in the entity's service area are reprocured or renewed at the same time.

~~(h)~~ (i) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services in the senate and the house of representatives describing in detail the activities undertaken by the commissioner to ensure full compliance with this section. The report must also provide an explanation for any decisions of the commissioner not to accept the recommendations of a county or group of counties required to be consulted under this section. The report must be provided at least 30 days prior to the effective date of a new or renewed prepaid or managed care contract in a county.

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

Sec. 19. **[256B.695] COUNTY-ADMINISTERED RURAL MEDICAL ASSISTANCE PROGRAM.**

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

(b) "CARMA" means the county-administered rural medical assistance program established under this section.

(c) "Commissioner" means the commissioner of human services.

(d) "Eligible individual" means an individual who is:

(1) residing in a county administering CARMA; and

(2) eligible for medical assistance, MinnesotaCare, Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), or Special Needs Basic Care (SNBC).

(e) "Enrollee" means an individual enrolled in CARMA.

(f) "PMAP" means the prepaid medical assistance program under section 256B.69.

(g) "Rural county" has the meaning given to "rural area" in Code of Federal Regulations, title 42, section 438.52.

Subd. 2. **Program established.** CARMA is established to:

(1) provide a county-owned and county-administered alternative to PMAP;

(2) facilitate integration of health care, public health, and social services to address health-related social needs in rural communities;

(3) account for the fewer enrollees and local providers of health care and community services in rural communities; and

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

Subd. 3. **County participation.** Each county or group of counties authorized under section 256B.692 may administer CARMA for any or all eligible individuals as an alternative to PMAP, MinnesotaCare, MSHO, MSC+, or SNBC programs. Counties choosing and authorized to administer CARMA are exempt from the procurement process as required under section 256B.69.

Subd. 4. **Oversight and regulation.** CARMA is governed by sections 256B.69 and 256B.692, unless otherwise provided for under this section. The commissioner must develop and implement a procurement process requiring applications from county-based purchasing plans interested in offering CARMA. The procurement process must require county-based purchasing plans to demonstrate compliance with federal and state regulatory requirements and the ability to meet the goals of the program set forth in subdivision 2. The commissioner must review and approve or disapprove applications.

Subd. 5. **CARMA enrollment.** (a) Subject to paragraphs (d) and (e), eligible individuals must be automatically enrolled in CARMA, but may decline enrollment. Eligible individuals may enroll in fee-for-service medical assistance. Eligible individuals may change their CARMA elections on an annual basis.

(b) Eligible individuals must be able to enroll in CARMA through the selection process in accordance with the election period established in section 256B.69, subdivision 4, paragraph (e).

(c) Enrollees who were not previously enrolled in the medical assistance program or MinnesotaCare can change their selection once within the first year after enrollment in CARMA. Enrollees who were not previously enrolled in CARMA have 90 days to make a change and changes are allowed for additional special circumstances.

(d) The commissioner may offer a second health plan other than, and in addition to, CARMA to eligible individuals when another health plan is required by federal law or rule. The commissioner may offer a replacement plan to eligible individuals, as determined by

the commissioner, when counties administering CARMA have their contract terminated for cause.

(e) The commissioner may, on a county-by-county basis, offer a health plan other than, and in addition to, CARMA to individuals who are eligible for both Medicare and medical assistance due to age or disability if the commissioner deems it necessary for enrollees to have another choice of health plan. Factors the commissioner must consider when determining if the other health plan is necessary include the number of available Medicare Advantage Plan options that are not special needs plans in the county, the size of the enrolling population, the additional administrative burden placed on providers and counties by multiple health plan options in a county, the need to ensure the viability and success of the CARMA program, and the impact to the medical assistance program.

(f) In counties where the commissioner is required by federal law or elects to offer a second health plan other than CARMA pursuant to paragraphs (d) and (e), eligible enrollees who do not select a health plan at the time of enrollment must automatically be enrolled in CARMA.

(g) This subdivision supersedes section 256B.694.

Subd. 6. **Benefits and services.** (a) Counties or groups of counties administering CARMA must cover all benefits and services required to be covered by medical assistance under section 256B.0625.

(b) Counties or groups of counties administering CARMA may include health-related social needs (HRSN) benefits as covered services under medical assistance as of January 1, 2030. Coverage for HRSN must be based on the assessed needs of housing, food, transportation, utilities, and interpersonal safety.

(c) Counties or groups of counties administering CARMA may reimburse enrollees directly for out-of-pocket costs incurred obtaining assessed HRSN services provided by nontraditional providers who are unable to accept payment via traditional health insurance methods. Enrollees must not be reimbursed for out-of-pocket costs paid to providers eligible to enroll.

Subd. 7. **Payment.** (a) The commissioner, in consultation with counties and groups of counties administering CARMA, must develop a mechanism for making payments to counties and groups of counties that administer CARMA. The payment mechanism must:

(1) be governed by contracts with terms, including but not limited to payment rates, amended on an as-needed basis;

(2) pay a full-risk monthly capitation payment for services included in CARMA, including the cost for administering CARMA benefits and services;

(3) include risk corridors based on minimum loss ratio, total cost of care, or other metrics;

(4) include a settle-up process tied to the risk corridor arrangement allowing a county or group of counties administering CARMA to retain savings for reinvestment in health care activities and operations to protect against significant losses that a county or group of counties administering CARMA or the state might realize, beginning no sooner than after a county's or group of counties' third year of CARMA operations;

(5) include a collaborative rate-setting process accounting for CARMA experience, regional experience, and the Department of Human Services fee-for-service experience; and

(6) be exempt from section 256B.69, subdivisions 5a, paragraphs (c) and (f), and 5d, and payment for Medicaid services provided under section 256B.69, subdivision 28, paragraph (b), no sooner than three years after CARMA implementation.

(b) Payments for benefits and services under subdivision 6, paragraph (a), must not exceed payments that otherwise would have been paid to health plans under medical assistance for that county or region. Payments for HRSN benefits under subdivision 6, paragraph (b), must be in addition to payments for benefits and services under subdivision 6, paragraph (a).

Subd. 8. **Quality measures.** (a) The commissioner and counties and groups of counties administering CARMA must collaborate to establish quality measures for CARMA not to exceed the extent of quality measures required under sections 256B.69 and 256B.692. The measures must include:

(1) enrollee experience and outcomes;

(2) population health;

(3) health equity; and

(4) the value of health care spending.

(b) The commissioner and counties and groups of counties administering CARMA must collaborate to define a quality improvement model for CARMA. The model must include a focus on locally specified measures based on counties' unique needs. The locally specified measures for the county or group of counties administering CARMA must be determined before the commissioner enters into any contract with a county or group of counties.

Subd. 9. **Data and systems integration.** The commissioner and counties and groups of counties administering CARMA must collaborate to:

(1) identify and address barriers that prevent counties and groups of counties administering CARMA from reviewing individual enrollee eligibility information to identify eligibility and to help enrollees apply for other appropriate programs and resources;

(2) identify and address barriers preventing counties and groups of counties administering CARMA from more readily communicating with and educating potential and current

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enrollees regarding other program opportunities, including helping enrollees apply for those programs and navigate transitions between programs;

(3) develop and test, in counties participating in CARMA, a universal public assistance application form to reduce the administrative barriers associated with applying for and participating in various public programs;

(4) identify and address regulatory and system barriers that may prohibit counties and groups of counties administering CARMA, agencies, and other partners from working together to identify and address an individual's needs;

(5) facilitate greater interoperability between counties and groups of counties administering CARMA, agencies, and other partners to send and receive the data necessary to support CARMA, counties, and local health system efforts to improve the health and welfare of prospective and enrolled populations;

(6) support efforts of counties and groups of counties administering CARMA to incorporate the necessary automation and interoperability to eliminate manual processes when related to the data exchanged; and

(7) support the creation and maintenance by counties and groups of counties administering CARMA of an updated electronic inventory of community resources available to assist the enrollee in the enrollee's HRSN, including an electronic closed-loop referral system.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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Sec. 16. Minnesota Statutes 2024, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **~~Physician and professional services~~ Reimbursement adjustments.** ~~(a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:~~

~~(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;~~

~~(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and~~

~~(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases~~

~~except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.~~

~~(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.~~

~~(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice registered nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.~~

~~(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice registered nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.~~

~~(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.~~

~~(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.~~

~~(g)~~ (a) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by 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. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

~~(h)~~ (b) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

~~(i)~~ (c) The commissioner may reimburse physicians and other licensed professionals for costs incurred to pay the fee for testing newborns who are medical assistance enrollees for heritable and congenital disorders under section 144.125, subdivision 1, paragraph (c), when the sample is collected outside of an inpatient hospital ~~or freestanding birth center~~ and the cost is not recognized by another payment source.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval of the amendments in this act to Minnesota Statutes, sections 256B.76, subdivision 6, and 256B.768, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2024, section 256B.76, subdivision 6, is amended to read:

Subd. 6. **Medicare relative value units.** (a) Effective for services rendered on or after January 1, 2007, the commissioner shall make payments for physician and professional services based on the Medicare relative value units (RVUs). This change shall be budget neutral and the cost of implementing RVUs will be incorporated in the established conversion factor. This paragraph expires on the date that paragraph (b) becomes effective.

(b) Effective January 1, 2026, or upon federal approval, whichever is later, and effective for services rendered on or after January 1, 2007, the commissioner must make payments for physician and professional services based on the Medicare relative value units (RVUs).

~~(b)~~ (c) Effective for services rendered on or after January 1, 2025, rates for mental health services reimbursed under the resource-based relative value scale (RBRVS) must be equal to 83 percent of the Medicare Physician Fee Schedule. This paragraph expires on the date that section 256B.768 becomes effective.

~~(c)~~ (d) Effective for services rendered on or after January 1, 2025, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increases provided under this subdivision. Managed care plans and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to the providers corresponding to the rate increases. The commissioner must monitor the effect of this rate increase on enrollee access to services under this subdivision. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this

paragraph. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph. This paragraph expires on the date that section 256B.768 becomes effective.

Sec. 18. Minnesota Statutes 2024, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

Subdivision 1. **Rates effective 2026.** ~~(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.~~

~~(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.~~

~~(c) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256K.10. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.~~

~~(d) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.~~

~~(e) Effective for services rendered on or after January 1, 2024, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, except for adult day treatment services under section 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services under section 256B.0949; and substance use disorder services under chapter 254B, must be increased by three percent from the rates in effect on December 31, 2023. Effective for services rendered on or after January 1, 2025, payment rates for behavioral health services included in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18; early intensive developmental behavioral intervention services under section~~

~~256B.0949; and substance use disorder services under chapter 254B, must be annually adjusted according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year. For payments made in accordance with this paragraph, if and to the extent that the commissioner identifies that the state has received federal financial participation for behavioral health services in excess of the amount allowed under United States Code, title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state money and maintain the full payment rate under this paragraph. This paragraph does not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, and rates that are negotiated with the county. This paragraph expires upon legislative implementation of the new rate methodology resulting from the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18.~~

~~(f) Effective January 1, 2024, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the behavioral health service rate increase provided in paragraph (e). Managed care and county-based purchasing plans must use the capitation rate increase provided under this paragraph to increase payment rates to behavioral health services providers. The commissioner must monitor the effect of this rate increase on enrollee access to behavioral health services. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision.~~

(a) Effective for services rendered on or after January 1, 2026, the commissioner must establish market-based payment rates for the following services:

(1) children's therapeutic services and supports under section 256B.0943;

(2) child and family psychoeducation services under section 256B.0671, subdivision 5;

(3) clinical care consultation services under section 256B.0671, subdivision 7; and

(4) mental health certified family peer specialist services under section 256B.0616.

(b) Rates established under paragraph (a) must not be lower than:

(1) the payment rates recommended in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, and published by the Department of Human Services on January 22, 2024; or

(2) the payment rates in effect on December 31, 2025.

Subd. 2. **Rates effective 2027.** (a) Effective for services rendered on or after January 1, 2027, the commissioner must establish market-based payment rates for the following services:

(1) adult day treatment services under section 256B.0671, subdivision 3;

(2) adult rehabilitative mental health services under section 256B.0623;

(3) adult mental health peer support specialist services under section 256B.0615;

(4) dialectical behavioral therapy under section 256B.0671, subdivision 6;

(5) explanation of findings under section 256B.0671, subdivision 4;

(6) mental health crisis response services under section 256B.0624;

(7) mental health provider travel time under section 256B.0625, subdivision 43;

(8) neuropsychological testing under section 256B.0671, subdivision 9;

(9) partial hospitalization services under section 256B.0671, subdivision 12; and

(10) psychotherapy services under section 256B.0671, subdivision 11, incorporating biofeedback.

(b) Rates established under paragraph (a) must not be lower than:

(1) the payments rates recommended in the rate analysis required by Laws 2021, First Special Session chapter 7, article 17, section 18, and published by the Department of Human Services on January 22, 2024; or

(2) the payment rates in effect on December 31, 2026.

Subd. 3. **Capitation payments.** The commissioner must adjust capitation payments made to managed care plans and county-based purchasing plans to reflect the behavioral health service rates provided in this section. Managed care and county-based purchasing plans must reimburse providers at an amount that is at least equal to the fee-for-service rate for services under this section. The commissioner must monitor the effect of this rate adjustment on enrollee access to behavioral health services. If for any contract year federal approval is not received for this subdivision, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this subdivision applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this subdivision. Payment recoveries must not exceed the amount equal to any increase in rates that results from this subdivision.

Subd. 4. **Inflation adjustment.** The commissioner must adjust the reimbursement rate for services under this section annually according to the change from the midpoint of the

previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year.

Subd. 5. **Exceptions.** (a) This section does not apply to federally qualified health centers, rural health centers, Indian health services, or certified community behavioral health clinics or to cost-based rates or rates that are negotiated with the county.

(b) This section does not apply to services with reimbursement rates established pursuant to section 256B.768.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval of this section and Minnesota Statutes, section 256B.768, whichever is later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 19. 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.** ~~(e)~~ (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, 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, 2025.

Subd. 14. **Rates for enteral nutrition and supplies.** ~~(n)~~ For dates of service on or after July 1, 2025, 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.

Subd. 15. **Rates for phototherapy services.** For dates of service on or after July 1, 2025, the payment rate for phototherapy services provided to newborns in the home setting must include a service fee in the amount of $520 per patient episode, in addition to the daily rental rate for the medical equipment in subdivision 12. The commissioner shall provide an annual inflation adjustment for the phototherapy service fee. The index for the inflation adjustment must be based on the Consumer Price Index for All Urban Consumers increase published by the Bureau of Labor Statistics.

Sec. 20. **[256B.768] MEDICARE RATE ALIGNMENT.**

Subdivision 1. **Medicare physician fee schedule rates.** (a) Effective January 1, 2026, or upon federal approval, whichever is later, and effective for services rendered on or after

January 1, 2026, or the date of federal approval, whichever is later, the commissioner must make payments based on the resource-based relative value scale for all services:

(1) covered in medical assistance; and

(2) with a corresponding rate and procedure code in the Medicare Physician Fee Schedule.

(b) Effective January 1, 2026, or upon federal approval, whichever is later, and effective for services rendered on or after January 1, 2026, or the date of federal approval, whichever is later, rates must be at least equal to 100 percent of the Medicare Physician Fee Schedule if the service:

(1) is reimbursed in medical assistance under the resource-based relative value scale; and

(2) has a corresponding rate and procedural code in the Medicare Physician Fee Schedule.

(c) For services rendered on or after January 1, 2026, the commissioner shall increase capitation payments made to managed care plans and county-based purchasing plans to reflect the rate increases provided under this subdivision. Managed care plans and county-based purchasing plans must reimburse providers at an amount that is at least equal to the fee-for-service rate for services under this subdivision. The commissioner must monitor the effect of this rate increase on enrollee access to services under this subdivision. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this paragraph. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph.

Subd. 2. **Applicable fee schedule.** For purposes of this section, the applicable Medicare Physician Fee Schedule is the most recent Medicare Physician Fee Schedule Final Rule issued by the Centers for Medicare and Medicaid Services in effect at the time the service was rendered.

Subd. 3. **Exceptions.** This section does not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, and rates that are negotiated with the county.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2024, section 295.50, subdivision 3, is amended to read:

Subd. 3. **Gross revenues.** (a) "Gross revenues" are total amounts received in money or otherwise by:

(1) a hospital for patient services;

(2) a surgical center for patient services;

(3) a health care provider, other than a staff model health plan company, for patient services;

(4) a wholesale drug distributor for sale or distribution of legend drugs that are delivered in Minnesota by the wholesale drug distributor, by common carrier, or by mail, unless the legend drugs are delivered to another wholesale drug distributor who sells legend drugs exclusively at wholesale; and

(5) a staff model health plan company as gross premiums for enrollees, co-payments, deductibles, coinsurance, and fees for patient services.

(b) For purposes of paragraph (a), clause (4), "gross revenues" includes the amount of any rebate provided by the wholesale drug distributor to a customer, however provided, including a rebate provided under a contractual obligation. "Rebate" means any price concession provided by a wholesale drug distributor, including any price concession based on the actual or estimated utilization, sale volume, or effectiveness of a legend drug.

EFFECTIVE DATE. This section is effective for gross revenues received after June 30, 2025.

Sec. 22. Minnesota Statutes 2024, section 295.52, subdivision 1, is amended to read:

Subdivision 1. **Hospital tax.** A tax is imposed on each hospital equal to ~~1.8~~ two percent of its gross revenues.

EFFECTIVE DATE. This section is effective for gross revenues received after June 30, 2025.

Sec. 23. Minnesota Statutes 2024, section 295.52, subdivision 1a, is amended to read:

Subd. 1a. **Surgical center tax.** A tax is imposed on each surgical center equal to ~~1.8~~ two percent of its gross revenues.

EFFECTIVE DATE. This section is effective for gross revenues received after June 30, 2025.

Sec. 24. Minnesota Statutes 2024, section 295.52, subdivision 2, is amended to read:

Subd. 2. **Provider tax.** A tax is imposed on each health care provider equal to ~~1.8~~ two percent of its gross revenues.

EFFECTIVE DATE. This section is effective for gross revenues received after June 30, 2025.

Sec. 25. Minnesota Statutes 2024, section 295.52, subdivision 3, is amended to read:

Subd. 3. **Wholesale drug distributor tax.** A tax is imposed on each wholesale drug distributor equal to ~~1.8~~ two percent of its gross revenues.

EFFECTIVE DATE. This section is effective for gross revenues received after June 30, 2025.

Sec. 26. Minnesota Statutes 2024, section 295.52, subdivision 4, is amended to read:

Subd. 4. **Use tax; legend drugs.** (a) A person that receives legend drugs for resale or use in Minnesota, other than from a wholesale drug distributor that is subject to tax under subdivision 3, is subject to a tax equal to the price paid for the legend drugs multiplied by ~~1.8~~ two percent. Liability for the tax is incurred when legend drugs are received or delivered in Minnesota by the person.

(b) A tax imposed under this subdivision does not apply to purchases by an individual for personal consumption.

EFFECTIVE DATE. This section is effective for gross revenues received after June 30, 2025.

Sec. 27. **[295.525] MCO ASSESSMENT ON HEALTH PLAN COMPANIES.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the definitions in this subdivision have the meanings given.

(b) "Commissioner" means the commissioner of human services.

(c) "Enrollee" has the meaning given in section 62Q.01, except that enrollee does not include:

(1) an individual enrolled in a Medicare plan;

(2) a plan-to-plan enrollee; or

(3) an individual enrolled in a health plan pursuant to the Federal Employees Health Benefits Act of 1959, Public Law 86-382, as amended, to the extent the imposition of the assessment under this section is preempted pursuant to United States Code, title 5, section 8909, subsection (f).

(d) "Health plan" has the meaning given in section 62Q.01.

(e) "Health plan company" has the meaning given in section 62Q.01.

(f) "Medical assistance" means the medical assistance program established under chapter 256B.

(g) "Medical assistance enrollee" means an enrollee in medical assistance or MinnesotaCare for whom the Department of Human Services directly pays the health plan company a capitated payment.

(h) "MinnesotaCare" means the MinnesotaCare program established under chapter 256L.

(i) "Plan-to-plan enrollee" means an individual who receives coverage for health care services through a health plan pursuant to a subcontract from another health plan.

Subd. 2. **MCO assessment.** (a) An annual assessment is imposed on health plan companies for each calendar year beginning in calendar year 2026. The total annual assessment amount is equal to the sum of the amounts assessed for medical assistance enrollees under paragraph (b) and for nonmedical assistance enrollees under paragraph (c).

(b) The amount assessed for medical assistance enrollees is equal to the sum of the following:

(1) for medical assistance enrollees 0 to 60,000, $0 per enrollee;

(2) for medical assistance enrollees 60,001 to 100,000, $340 per enrollee;

(3) for medical assistance enrollees 100,001 to 200,000, $365 per enrollee; and

(4) for medical assistance enrollees 200,001 to 350,000, $380 per enrollee.

(c) The amount assessed for nonmedical assistance enrollees is equal to the sum of the following:

(1) for nonmedical assistance enrollees 0 to 60,000, $0 per enrollee;

(2) for nonmedical assistance enrollees 60,001 to 100,000, 50 cents per enrollee;

(3) for nonmedical assistance enrollees 100,001 to 200,000, 75 cents per enrollee; and

(4) for nonmedical assistance enrollees 200,001 to 350,000, $1 per enrollee.

(d) The commissioner must annually use the commissioner's authority as necessary to modify the rate of assessment, provided under paragraph (e), such that the annual assessment imposed under this subdivision does not exceed the lesser of:

(1) 2.8 percent of the health plan companies' aggregate gross revenue; and

(2) the cumulative costs attributable to:

(i) the program changes in section 295.525, subdivision 4, paragraph (b), clauses (1) to (6); and

(ii) the appropriation under section 144E.54, subdivision 10.

(e) The commissioner may, after consultation with health plan companies likely to be affected, modify the rate of assessment, as set forth in paragraphs (a) to (d), as necessary to:

(1) comply with federal law, obtain or maintain a waiver under Code of Federal Regulations, title 42, section 433.72, or to otherwise maximize under this section federal financial participation for medical assistance; and

(2) comply with paragraph (d).

(f) Unpaid assessment amounts accrue interest at a rate of ten percent per annum, beginning the day following the assessment payment's due date. A penalty, equal to the total accrued interest charge, is imposed monthly on payments 60 days or more overdue until the payment, penalty, and interest are paid in full.

Subd. 3. **Assessment computation; collection.** (a) The commissioner must annually determine the following for each health plan company:

(1) total enrollment for the calendar year;

(2) total Medicare enrollment for the calendar year;

(3) total medical assistance enrollment for the calendar year;

(4) total plan-to-plan enrollment for the calendar year;

(5) total enrollment through the Federal Employees Health Benefits Act of 1959, Public Law 86-382, as amended, for the calendar year; and

(6) total other enrollment for the calendar year that is not otherwise counted in clauses (2) to (5).

(b) Health plan companies must provide any information requested by the commissioner for the purpose of this subdivision, provided that the commissioner determines such information is necessary to accurately determine the information in paragraph (a).

(c) The commissioner may correct errors in data provided to the commissioner by a health plan company to the extent necessary to accurately determine the information in paragraph (a).

(d) For purposes of calculating the information in paragraph (a) for a health plan company, the commissioner must count any individual that was an enrollee of a health plan at any point of the calendar year, regardless of the enrollee's duration as an enrollee of the health plan.

(e) The commissioner must annually use the information in paragraph (a) to compute the assessment for each health plan company.

(f) The commissioner must collect the annual assessment for each health plan company in four equal installments, in the manner and on the schedule determined by the

commissioner. The commissioner is prohibited from collecting any amount under this section until 20 days after the commissioner has notified the health plan company of:

(1) the effective date of this section;

(2) the assessment due dates for the applicable calendar year; and

(3) the annual assessment amount.

(g) The commissioner may waive all or part of the interest or penalty imposed on a health plan company under subdivision 2, paragraph (f), if the commissioner determines the interest or penalty is likely to create an undue financial hardship on the health plan company or a significant financial difficulty in providing necessary services to medical assistance enrollees. A waiver under this paragraph must be contingent on the health plan company's agreement to make assessment payments on an alternative schedule, determined by the commissioner, that accounts for the health plan company's finances and the potential impact on the delivery of services to medical assistance enrollees.

(h) In the event of a merger, acquisition, or other transaction that results in the transfer of health plan responsibility to another health plan company or similar entity during calendar years 2026 to 2029, the surviving, acquiring, or controlling health plan company or similar entity shall be responsible for paying the full assessment amount as provided in this section that would have been the responsibility of the health plan company to which that full assessment amount was assessed upon the effective date of the transaction. If a transaction results in the transfer of health plan responsibility for only some of a health plan's enrollees under this section but not all enrollees, the full assessment amount as provided in this section remains the responsibility of that health plan company to which that full assessment amount was assessed.

Subd. 4. **MCO assessment expenditures.** (a) All amounts collected by the commissioner under this section must be deposited in the health care access fund.

(b) Of the total amount collected by the commissioner under this section, $18,000,000 annually is for the appropriation under section 144E.54, subdivision 10. All other amounts collected by the commissioner under this section are annually appropriated to the commissioner to provide nonfederal money for medical assistance and MinnesotaCare program rate changes made in this act related to:

(1) ambulance services under section 256B.0625, subdivision 17a;

(2) behavioral health home services under section 256B.0757;

(3) mental health services under section 256B.761;

(4) services reimbursed under the resource-based relative value scale and with a corresponding rate and procedural code in the Medicare Physician Fee Schedule under section 256B.768;

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Sec. 20. **IMPLEMENTATION OF HOSPITAL ASSESSMENT AND DIRECTED PAYMENT PROGRAM.**

(a) The commissioner of human services must immediately begin all necessary claims analysis to calculate the assessment and payments required under Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program described in Minnesota Statutes, section 256B.1974.

(b) The commissioner of human services, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services a request for federal approval to implement the hospital assessment described in Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program under Minnesota Statutes, section 256B.1974. At least 15 days before submitting the request for approval, the commissioner must make available to the public the draft assessment requirements, the draft directed payment details, and an estimate of each assessment amount for each eligible hospital without an exemption from the assessment pursuant to Minnesota Statutes, section 256.9657, subdivision 2b, paragraph (k).

(c) During the design and prior to submission of the request for approval under paragraph (b), the commissioner of human services must consult with the Minnesota Hospital Association and any eligible hospitals without an exemption from the assessment pursuant

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(5) inpatient behavioral health services provided by hospitals paid under the DRG methodology under section 256.969, subdivision 2b, paragraph (l); and

(6) mental health services provided by masters-prepared mental health professionals and physician assistants resulting from the repeal of section 256B.0625, subdivision 38.

(c) Except for the amount necessary for the appropriation under section 144E.54, subdivision 10, the assessment money must be used to supplement money for medical assistance from the general fund.

(d) The commissioner must provide an annual report to all health plan companies, in a time and manner determined by the commissioner. The report must identify the assessments imposed on each health plan company pursuant to this section, account for all money raised by the MCO assessment, and provide an itemized accounting of expenditures from the fund.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval for the assessment established in this section to be considered a permissible health care-related tax under Code of Federal Regulations, title 42, section 433.68, eligible for federal financial participation, including but not limited to federal approval of a waiver under Code of Federal Regulations, title 42, section 433.72, if such waiver is necessary to receive health care-related taxes without a reduction in federal financial participation, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 29. **IMPLEMENTATION OF HOSPITAL ASSESSMENT AND DIRECTED PAYMENT PROGRAM.**

(a) The commissioner of human services must immediately begin all necessary claims analysis to calculate the assessment and payments required under Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program described in Minnesota Statutes, section 256B.1974.

(b) The commissioner of human services, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services a request for federal approval to implement the hospital assessment described in Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program under Minnesota Statutes, section 256B.1974. At least 15 days before submitting the request for approval, the commissioner must make available to the public the draft assessment requirements, draft directed payment details, and an estimate of each assessment amount for each hospital without an exemption from the assessment pursuant to Minnesota Statutes, section 256.9657, subdivision 2b, paragraph (k).

(c) During the design and prior to submission of the request for approval under paragraph (b), the commissioner of human services must consult with the Minnesota Hospital Association and any hospitals without an exemption from the assessment pursuant to

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to Minnesota Statutes, section 256.9657, subdivision 2b, paragraph (k), and that are not members of the Minnesota Hospital Association.

(d) If federal approval is received for the request under paragraph (b), the commissioner of human services must provide at least 15 days of public posting and review of the federally approved terms and conditions for the assessment and the directed payment program prior to any assessment under Minnesota Statutes, section 256.9657, subdivision 2b, becoming due from an eligible hospital.

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

Sec. 21. **REQUEST FOR FEDERAL WAIVER.**

The commissioner of human services must seek all federal waivers and authority necessary to implement the county-assisted rural medical assistance (CARMA) program under Minnesota Statutes, section 256B.695. Any part of the CARMA program that does not require federal approval shall have an effective date as specified in state law. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Sec. 22. **COUNTY-ADMINISTERED RURAL MEDICAL ASSISTANCE PROGRAM IMPLEMENTATION COSTS.**

Up to $500,000 of the nonfederal share of the costs to the Department of Human Services for implementation of the requirements under the county-assisted rural medical assistance (CARMA) program under Minnesota Statutes, section 256B.695, must be paid via an intergovernmental funds transfer to the commissioner of human services by each county or group of counties authorized under Minnesota Statutes, section 256B.692, seeking to administer a CARMA program. The costs must be paid in a manner that is in compliance with the requirements of Code of Federal Regulations, title 42, section 433.51. Within one year of receiving payment under this section, the commissioner must provide a settle-up process for any county or group of counties authorized under Minnesota Statutes, section 256B.692, administering a CARMA program and making payment under this section to document and adjust payments owed to account for the commissioner's actual implementation costs for Minnesota Statutes, section 256B.695.

Sec. 23. **MEDICAL ASSISTANCE COVERAGE OF TRADITIONAL HEALTH CARE PRACTICES.**

Subdivision 1. **Waiver request.** By October 1, 2025, the commissioner of human services, in consultation with Tribes, Tribal organizations, and urban Indian organizations, shall apply to the Centers for Medicare and Medicaid Services for a waiver to allow the state's medical assistance program to provide coverage for traditional health care practices received through Indian health service facilities, facilities operated by Tribes or Tribal organizations under

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Minnesota Statutes, section 256.9657, subdivision 2b, paragraph (k), and that are not members of the Minnesota Hospital Association.

(d) If federal approval is received for the request under paragraph (b), the commissioner of human services must provide at least 15 days of public posting and review of the federally approved terms and conditions for the assessment and the directed payment program prior to any assessment under Minnesota Statutes, section 256.9657, subdivision 2b, becoming due from a hospital.

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

the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act.

Subd. 2. **Requirements.** (a) A qualified provider must determine whether a medical assistance enrollee is eligible to receive traditional health care practices under this section.

(b) Traditional health care practices are covered under this section if they are received from a qualified provider.

(c) For purposes of this section, "qualified provider" means a practitioner or provider who is employed by or under contract with the Indian Health Service, a 638 Tribal clinic, or a Title V urban Indian organization. Each facility is responsible for ensuring that a qualified provider has the necessary experience and appropriate training to provide traditional health care practices.

Subd. 3. **Payments for traditional health care practices.** Reimbursement for traditional health care practices under this section is set at the outpatient, per-visit rate established by the Indian Health Service under sections 321(a) and 322(b) of the Public Health Service Act. Reimbursement is limited to one payment per day, per medical assistance enrollee receiving traditional health care practices.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later, except that subdivision 1 is effective the day following final enactment. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 24. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; ENHANCED FEDERAL REIMBURSEMENT FOR FAMILY PLANNING SERVICES IN MEDICAL ASSISTANCE.**

The commissioner of human services must make the systems modification necessary to claim enhanced federal reimbursement for all family planning services under the medical assistance program.

Sec. 25. **DENTAL ACCESS WORKING GROUP.**

Subdivision 1. **Establishment.** (a) The commissioner of human services must establish a working group as part of the Dental Services Advisory Committee to identify and make recommendations on the state's goals, priorities, and processes for contracting with a dental administrator under Minnesota Statutes, section 256B.0371.

(b) The working group must include members of the Dental Services Advisory Committee, and at least one representative from each of the following:

(1) critical access dental providers;

Sec. 28. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; ENHANCED FEDERAL REIMBURSEMENT FOR FAMILY PLANNING SERVICES IN MEDICAL ASSISTANCE.**

The commissioner of human services must make the systems modification necessary to claim enhanced federal reimbursement for all family planning services under the medical assistance program.

(2) dental providers that primarily serve low-income and socioeconomically complex populations;

(3) dental providers that serve private-pay patients as well as medical assistance and MinnesotaCare enrollees;

(4) rural critical access dental providers that do not have clinics in the seven-county metropolitan area as defined in Minnesota Statutes, section 473.121, subdivision 2; and

(5) managed care plans.

Subd. 2. **Recommendations.** (a) The working group must provide recommendations to the commissioner on:

(1) establishing and implementing a dental payment rate structure for medical assistance and MinnesotaCare that:

(i) is based on the most recent cost data available;

(ii) promotes accountability while considering geographic differences in access to and cost of dental services, critical access dental status, patient characteristics, transportation needs, and medical and dental benefit coordination; and

(iii) can be updated regularly;

(2) performance benchmarks that focus on improving oral health for medical assistance and MinnesotaCare enrollees, including consideration of Dental Quality Alliance and Oral Health Impact Profile measures for broader assessment of a full range of services, and the feasibility, cost, and value of providing the services;

(3) methods for measuring progress toward the performance benchmarks and holding the dental administrator accountable for progress, including providing rewards for progress;

(4) establishing goals and processes to ensure coordination of care among medical assistance and MinnesotaCare providers, including dental, medical, and other care providers, particularly for patients with complex cases engaged in active treatment plans at the time of transition to the dental administrator under Minnesota Statutes, section 256B.0371;

(5) developing and implementing an infrastructure and workforce development strategy that invests in the medical assistance and MinnesotaCare dental system through grants and loans at a level that enables continued development of dental capacity commensurate with that obtained through the managed care delivery system and from philanthropic sources; and

(6) developing and implementing a workforce development strategy to support the pipeline of dental providers and oral health practitioners at all levels.

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(b) The working group must provide the recommendations required under this subdivision to the commissioner by .....

Subd. 3. **Reporting requirements.** (a) By ....., the commissioner, in consultation with its contracted dental administrator, must develop an implementation plan and timeline to effectuate the recommendations from the working group under this section.

(b) By ....., the commissioner must submit a report with the working group recommendations, implementation plan, timeline, and any draft legislation required to implement the implementation plan to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

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Sec. 30. **FEDERAL APPROVAL; WAIVERS.**

(a) The commissioner must request, as the commissioner determines necessary, federal approval for the MCO assessment on health plan companies established in this act to be considered a permissible health-care-related tax under Code of Federal Regulations, title 42, section 433.68, eligible for federal financial participation.

(b) To obtain the federal approval under paragraph (a), the commissioner may apply for a waiver of the federal broad-based requirement for health care-related taxes, uniform requirement for health-care-related taxes, and any other provision of federal law necessary to implement Minnesota Statutes, section 295.525.

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

Sec. 31. **BUDGET NEUTRALITY; RATE ADJUSTMENTS.**

(a) By October 1 of each year, the commissioner of human services must determine the difference between the actual costs or forecasted costs to the medical assistance and MinnesotaCare programs attributable to the program changes in Minnesota Statutes, section 295.525, subdivision 4, paragraph (b), clauses (1) to (6), and the revenue from the MCO assessment imposed under Minnesota Statutes, section 295.525, subdivision 2, including federal financial participation.

(b) For each fiscal year, the commissioner of human services must certify the difference between the actual costs or forecasted costs to the medical assistance and MinnesotaCare programs determined under paragraph (a), and report the difference in costs to the commissioner of management and budget at least four weeks prior to a forecast under Minnesota Statutes, section 16A.103.

(c) If for any fiscal year, the cumulative costs attributable to: (1) the program changes in Minnesota Statutes, section 295.525, subdivision 4, paragraph (b), clauses (1) to (6), and (2) the appropriation under section 144E.54, subdivision 10, exceed revenue from the MCO assessment imposed under Minnesota Statutes, section 295.525, subdivision 2, as determined under paragraph (a), the commissioner of human services must reduce the costs to the

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Sec. 26. **REPEALER.**

(a) Laws 2023, chapter 70, article 16, section 22, is repealed.

(b) Minnesota Statutes 2024, section 256B.0625, subdivisions 18b, 18e, and 18h, are repealed.

EFFECTIVE DATE. Paragraph (b) is effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

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medical assistance and MinnesotaCare programs attributable to the program changes in Minnesota Statutes, section 295.525, subdivision 4, paragraph (b), clauses (1) to (6). The commissioner's reduction under this paragraph must be on a uniform percentage basis across the rate increases provided in Minnesota Statutes, section 295.525, subdivision 4, paragraph (b), clauses (1) to (6).

Sec. 32. **TREND LIMIT; CALCULATION.**

(a) Beginning January 1, 2027, and ending June 30, 2029, the commissioner of human services may limit the trend increase in rates paid to managed care plans and county-based purchasing plans under Minnesota Statutes, sections 256B.69 and 256B.692, by an amount equal to the value of a 0.35 percent reduction in trend in medical assistance. Managed care rates must meet actuarial soundness and rate development requirements under Code of Federal Regulations, title 42, part 438, subpart A.

(b) In the November 2025 forecast, the commissioner of human services, in consultation with the commissioner of management and budget, must reduce the forecasted trend growth in managed care for medical assistance expenditures in fiscal years 2027, 2028, and 2029. The reduction must not be less than $7,784,000 in fiscal year 2027, $8,219,000 in fiscal year 2028, and $8,446,000 in fiscal year 2029.

Sec. 33. **PROGRAM FOR AMBULANCE SERVICE PROVIDER FUNDING.**

The commissioner of human services may implement a voluntary program to increase funding to ambulance service providers licensed under Minnesota Statutes, chapter 144E, for services delivered to enrollees of fee-for-service medical assistance and medical assistance delivered by managed care and county-based purchasing plans. In developing the program, the commissioner of human services must consider a range of approaches, including but not limited to intergovernmental transfer and certified public expenditure programs, as allowed under Code of Federal Regulations, title 42, section 433.51. The program must supplement, and not supplant or replace, any existing programs operated by the commissioner of human services to increase funding to ambulance service providers.

Sec. 34. **REPEALER.**

Minnesota Statutes 2024, section 256B.0625, subdivision 38, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval of this section and the amendments in this act to Minnesota Statutes, sections 256B.76, subdivision 6, and 256B.761, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.