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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

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

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

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

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

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

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

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

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

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

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

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

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

44.31 Subd. 3. **Other standards; wheelchair securement; protected transport.** (a) A special

44.32 transportation service that transports individuals occupying wheelchairs is subject to the

44.33 provisions of sections 299A.11 to 299A.17 concerning wheelchair securement devices. The

44.34 commissioners of transportation and public safety shall cooperate in the enforcement of

45.1 this section and sections 299A.11 to 299A.17 so that a single inspection is sufficient to

45.2 ascertain compliance with sections 299A.11 to 299A.17 and with the standards adopted

45.3 under this section. Representatives of the Department of Transportation may inspect

45.4 wheelchair securement devices in vehicles operated by special transportation service

45.5 providers to determine compliance with sections 299A.11 to 299A.17 and to issue certificates

45.6 under section 299A.14, subdivision 4.

45.7 (b) In place of a certificate issued under section 299A.14, the commissioner may issue

45.8 a decal under subdivision 4 for a vehicle equipped with a wheelchair securement device if

45.9 the device complies with sections 299A.11 to 299A.17 and the decal displays the information

45.10 in section 299A.14, subdivision 4.

45.11 (c) For vehicles designated as protected transport under section 256B.0625, subdivision

45.12 17, paragraph ~~(H)~~ (n), the commissioner of transportation, during the commissioner's

45.13 inspection, shall check to ensure the safety provisions contained in that paragraph are in

45.14 working order.

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

45.16 Subd. 2. **Hospital surcharge.** (a) Effective October 1, 1992, each Minnesota hospital

45.17 except facilities of the federal Indian Health Service and regional treatment centers shall

45.18 pay to the ~~medical assistance account~~ health care access fund a surcharge equal to 1.4 percent

45.19 of net patient revenues excluding net Medicare revenues reported by that provider to the

45.20 health care cost information system according to the schedule in subdivision 4.

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

45.22 (c) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital

45.23 surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to

45.24 256.9695.

211.9 or evidence-based standards has recommended changes in usage of the service for reasons

211.10 related to previously unknown and imminent patient harm.

211.11 (e) Paragraph (a) does not apply if a utilization review organization removes a brand

211.12 name drug from its formulary or places a brand name drug in a benefit category that increases

211.13 the enrollee's cost, provided the utilization review organization (1) adds to its formulary a

211.14 generic or multisource brand name drug rated as therapeutically equivalent according to

211.15 the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA

211.16 Purple Book, at a lower cost to the enrollee, and (2) provides at least a 60-day notice to

211.17 prescribers, pharmacists, and affected enrollees.

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

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

45.29 (1) "eligible hospital" means a hospital:

45.30 (i) licensed under section 144.50;

45.31 (ii) located in Minnesota; and

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

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

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

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

46.11 (1) \$120.22 multiplied by total patient days; and

46.12 (2) 5.96 percent of the hospital's net outpatient revenue.

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

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

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

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

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

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

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

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

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

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

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

212.1 (1) \$120.22 multiplied by total patient days; and

212.2 (2) 5.96 percent of the hospital's net outpatient revenue.

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

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

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

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

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

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

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

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

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

47.17 (k) Revenue from an assessment under this subdivision must only be used by the
47.18 commissioner to pay the nonfederal share of the directed payment program under section
47.19 256B.1974.

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

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

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

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

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

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

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

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

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

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

213.6 (k) Revenue from an assessment under this subdivision must only be used by the
213.7 commissioner to pay the nonfederal share of the directed payment program under section
213.8 256B.1974.

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

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

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

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

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

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

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

48.5 (4) each hospital not included in another discount category, and with greater than
48.6 \$200,000,000 in total medical assistance inpatient and outpatient revenue in fee-for-service
48.7 and managed care, as reported in the state fiscal year 2022 Medicare cost report, with a
48.8 discount of five percent off the inpatient portion of the assessment rate; and

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

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

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

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

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

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

48.24 (5) each hospital not included in another discount category, and with greater than
48.25 \$200,000,000 in total medical assistance inpatient and outpatient revenue in fee-for-service

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

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

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

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

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

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

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

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

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

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

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

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

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

48.30 (1) federal Indian Health Service facilities;
48.31 (2) state-owned or state-operated regional treatment centers and all state-operated services;
48.32 (3) federal Veterans Administration Medical Centers; and
49.1 (4) long-term acute care hospitals.

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

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

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

49.15 (1) the waiver for the assessment required under this section; and
49.16 (2) the amendments in this act to Minnesota Statutes, sections 256B.1973 and 256B.1974.

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

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

214.7 (1) federal Indian Health Service facilities;
214.8 (2) state-owned or state-operated regional treatment centers and all state-operated services;
214.9 (3) federal Veterans Administration Medical Centers; and
214.10 (4) long-term acute care hospitals.

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

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

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

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

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

214.32 (1) this section; and
215.1 (2) the amendments in this act to Minnesota Statutes, sections 256B.1973 and 256B.1974.

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

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

215.5 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
215.6 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
215.7 to the following:

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

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

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

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

215.16 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
215.17 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
215.18 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
215.19 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
215.20 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
215.21 years are updated, a Minnesota long-term hospital's base year shall remain within the same
215.22 period as other hospitals.

215.23 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
215.24 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
215.25 area, except for the hospitals paid under the methodologies described in paragraph (a),
215.26 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
215.27 manner similar to Medicare. The base year or years for the rates effective November 1,
215.28 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,
215.29 ensuring that the total aggregate payments under the rebased system are equal to the total
215.30 aggregate payments that were made for the same number and types of services in the base
215.31 year. Separate budget neutrality calculations shall be determined for payments made to
215.32 critical access hospitals and payments made to hospitals paid under the DRG system. Only
215.33 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being
216.1 rebased during the entire base period shall be incorporated into the budget neutrality
216.2 calculation.

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

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

216.13 (1) pediatric services;

216.14 (2) behavioral health services;

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

216.16 (4) transplant services;

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

216.19 (6) outlier admissions;

216.20 (7) low-volume providers; and

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

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

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

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

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

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

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

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

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

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

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

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

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

- 218.19 (1) the ratio between the hospital's costs for treating medical assistance patients and the
218.20 hospital's charges to the medical assistance program;
- 218.21 (2) the ratio between the hospital's costs for treating medical assistance patients and the
218.22 hospital's payments received from the medical assistance program for the care of medical
218.23 assistance patients;
- 218.24 (3) the ratio between the hospital's charges to the medical assistance program and the
218.25 hospital's payments received from the medical assistance program for the care of medical
218.26 assistance patients;
- 218.27 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);
- 218.28 (5) the proportion of that hospital's costs that are administrative and trends in
218.29 administrative costs; and
- 218.30 (6) geographic location.
- 218.31 (k) Subject to subdivision 2g, effective for discharges occurring on or after January 1,
218.32 2024, the rates paid to hospitals described in paragraph (a), clauses (2) to (4), must include
219.1 a rate factor specific to each hospital that qualifies for a medical education and research
219.2 cost distribution under section 62J.692, subdivision 4, paragraph (a).
- 219.3 (l) Effective for discharges occurring on or after January 1, 2028, or on or after the date
219.4 of federal approval, whichever is later, the commissioner must increase by an annual
219.5 aggregate amount of \$10,000,000:
- 219.6 (1) payments for inpatient behavioral health services provided by hospitals paid under
219.7 the DRG methodology by increasing the adjustment for behavioral health services under
219.8 section 256.969, subdivision 2b, paragraph (e); and
- 219.9 (2) capitation payments made to managed care plans and county-based purchasing plans
219.10 to reflect the rate increase provided under this paragraph. Managed care and county-based
219.11 purchasing plans must use the capitation rate increase provided under this clause to increase
219.12 payment rates for inpatient behavioral health services provided by hospitals paid under the
219.13 DRG methodology. The commissioner must monitor the effect of this rate increase on
219.14 enrollee access to behavioral health services. If for any contract year federal approval is not
219.15 received for this clause, the commissioner must adjust the capitation rates paid to managed
219.16 care plans and county-based purchasing plans for that contract year to reflect the removal
219.17 of this clause. Contracts between managed care plans and county-based purchasing plans
219.18 and providers to whom this paragraph applies must allow recovery of payments from those
219.19 providers if capitation rates are adjusted in accordance with this clause. Payment recoveries
219.20 must not exceed the amount equal to any increase in rates that results from this paragraph.
- 219.21 **EFFECTIVE DATE.** This section is effective the day following final enactment.

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

49.20 Subd. 2f. **Alternate inpatient payment rate.** (a) Effective January 1, 2022, for a hospital

49.21 eligible to receive disproportionate share hospital payments under subdivision 9, paragraph

49.22 (d), clause (6), the commissioner shall reduce the amount calculated under subdivision 9,

49.23 paragraph (d), clause (6), by 99 percent and compute an alternate inpatient payment rate.

49.24 The alternate payment rate shall be structured to target a total aggregate reimbursement

49.25 amount equal to what the hospital would have received for providing fee-for-service inpatient

49.26 services under this section to patients enrolled in medical assistance had the hospital received

49.27 the entire amount calculated under subdivision 9, paragraph (d), clause (6). This paragraph

49.28 expires when paragraph (b) becomes effective.

49.29 (b) For hospitals eligible to receive payment under section 256B.1973 or 256B.1974

49.30 and meeting the criteria in subdivision 9, paragraph (d), the commissioner shall reduce the

49.31 amount calculated under subdivision 9, paragraph (d), by one percent and compute an

49.32 alternate inpatient payment rate. The alternate payment rate shall be structured to target a

49.33 total aggregate reimbursement amount equal to what the hospital would have received for

50.1 providing fee-for-service inpatient services under this section to patients enrolled in medical

50.2 assistance had the hospital received 99 percent of the entire amount calculated under

50.3 subdivision 9, paragraph (d). Hospitals that do not meet federal requirements for Medicaid

50.4 disproportionate share hospitals are not eligible for this alternate payment.

50.5 **EFFECTIVE DATE.** (a) Paragraph (b) of this section is effective the later of January

50.6 1, 2026, or federal approval of all of the following:

50.7 (1) this section; and

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

50.9 (b) The commissioner of human services shall notify the revisor of statutes when federal

50.10 approval for all amendments set forth in paragraph (a) is obtained.

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

50.12 Subd. 3. **Contingent contract with dental administrator.** (a) The commissioner shall

50.13 determine the extent to which managed care and county-based purchasing plans in the

50.14 aggregate meet the performance benchmark specified in subdivision 1 for coverage year

50.15 2024. If managed care and county-based purchasing plans in the aggregate fail to meet the

50.16 performance benchmark, the commissioner, after issuing a request for information followed

50.17 by a request for proposals, shall contract with a dental administrator to administer dental

50.18 services beginning January 1, 2026, 2028, for all recipients of medical assistance and

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

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

262.14 Subd. 3. **Contingent contract with dental administrator.** (a) The commissioner shall

262.15 determine the extent to which managed care and county-based purchasing plans in the

262.16 aggregate meet the performance benchmark specified in subdivision 1 for coverage year

262.17 2024. If managed care and county-based purchasing plans in the aggregate fail to meet the

262.18 performance benchmark, the commissioner, after issuing a request for information followed

262.19 by a request for proposals, shall contract with a dental administrator to administer dental

262.20 services beginning January 1, 2026, 2030, for all recipients of medical assistance and

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

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

50.23 (1) provider recruitment, contracting, and assistance;

50.24 (2) recipient outreach and assistance;

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

50.26 (4) dental claims processing;

50.27 (5) coordination of dental care with other services;

50.28 (6) management of fraud and abuse;

50.29 (7) monitoring access to dental services statewide;

50.30 (8) performance measurement;

51.1 (9) quality improvement and evaluation; and

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

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

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

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

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

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

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

262.25 (1) provider recruitment, contracting, and assistance;

262.26 (2) recipient outreach and assistance;

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

262.28 (4) dental claims processing;

262.29 (5) coordination of dental care with other services;

262.30 (6) management of fraud and abuse;

263.1 (7) monitoring access to dental services;

263.2 (8) performance measurement;

263.3 (9) quality improvement and evaluation; and

263.4 (10) management of third-party liability requirements;

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

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

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

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

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

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

52.1 The rules shall provide:

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

52.5 (2) reimbursement of public and private nonprofit providers serving the population with
 52.6 a disability generally at reasonable maximum rates that reflect the cost of providing the
 52.7 service regardless of the fare that might be charged by the provider for similar services to
 52.8 individuals other than those receiving medical assistance or medical care under this chapter.
 52.9 This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1,
 52.10 2027, for prepaid medical assistance.

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

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

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

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

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

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

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

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

53.6 (1) eyeglasses;

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

53.10 (3) hearing aids and supplies;

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

53.12 (i) hospital beds;

53.13 (ii) commodes;

53.14 (iii) glide-about chairs;

53.15 (iv) patient lift apparatus;

53.16 (v) wheelchairs and accessories;

53.17 (vi) oxygen administration equipment;

53.18 (vii) respiratory therapy equipment;

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

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

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

53.25 (6) drugs; and

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

53.27 This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1,
53.28 2027, for prepaid medical assistance.

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

54.4 (1) eyeglasses;

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

54.8 (3) hearing aids and supplies;

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

54.10 (i) hospital beds;

54.11 (ii) commodes;

54.12 (iii) glide-about chairs;

54.13 (iv) patient lift apparatus;

54.14 (v) wheelchairs and accessories;

54.15 (vi) oxygen administration equipment;

54.16 (vii) respiratory therapy equipment; and

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

54.18 (5) nonemergency medical transportation; and

54.19 (6) drugs.

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

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

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

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

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

55.2 Subd. 3b. **Telehealth services.** (a) Medical assistance covers medically necessary services

55.3 and consultations delivered by a health care provider through telehealth in the same manner

55.4 as if the service or consultation was delivered through in-person contact. Services or

55.5 consultations delivered through telehealth shall be paid at the full allowable rate.

55.6 (b) The commissioner may establish criteria that a health care provider must attest to in

55.7 order to demonstrate the safety or efficacy of delivering a particular service through

55.8 telehealth. The attestation may include that the health care provider:

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

55.10 through telehealth;

55.11 (2) has written policies and procedures specific to services delivered through telehealth

55.12 that are regularly reviewed and updated;

55.13 (3) has policies and procedures that adequately address patient safety before, during,

55.14 and after the service is delivered through telehealth;

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

55.16 and

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

55.18 telehealth.

55.19 (c) As a condition of payment, a licensed health care provider must document each

55.20 occurrence of a health service delivered through telehealth to a medical assistance enrollee.

55.21 Health care service records for services delivered through telehealth must meet the

55.22 requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must

55.23 document:

55.24 (1) the type of service delivered through telehealth;

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

55.26 designation;

55.27 (3) the health care provider's basis for determining that telehealth is an appropriate and

55.28 effective means for delivering the service to the enrollee;

55.29 (4) the mode of transmission used to deliver the service through telehealth and records

55.30 evidencing that a particular mode of transmission was utilized;

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

56.1 (6) if the claim for payment is based on a physician's consultation with another physician

56.2 through telehealth, the written opinion from the consulting physician providing the telehealth

56.3 consultation; and

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

219.23 Subd. 3b. **Telehealth services.** (a) Medical assistance covers medically necessary services

219.24 and consultations delivered by a health care provider through telehealth in the same manner

219.25 as if the service or consultation was delivered through in-person contact. Services or

219.26 consultations delivered through telehealth shall be paid at the full allowable rate.

219.27 (b) The commissioner may establish criteria that a health care provider must attest to in

219.28 order to demonstrate the safety or efficacy of delivering a particular service through

219.29 telehealth. The attestation may include that the health care provider:

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

219.31 through telehealth;

219.32 (2) has written policies and procedures specific to services delivered through telehealth

219.33 that are regularly reviewed and updated;

220.1 (3) has policies and procedures that adequately address patient safety before, during,

220.2 and after the service is delivered through telehealth;

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

220.4 and

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

220.6 telehealth.

220.7 (c) As a condition of payment, a licensed health care provider must document each

220.8 occurrence of a health service delivered through telehealth to a medical assistance enrollee.

220.9 Health care service records for services delivered through telehealth must meet the

220.10 requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must

220.11 document:

220.12 (1) the type of service delivered through telehealth;

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

220.14 designation;

220.15 (3) the health care provider's basis for determining that telehealth is an appropriate and

220.16 effective means for delivering the service to the enrollee;

220.17 (4) the mode of transmission used to deliver the service through telehealth and records

220.18 evidencing that a particular mode of transmission was utilized;

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

220.20 (6) if the claim for payment is based on a physician's consultation with another physician

220.21 through telehealth, the written opinion from the consulting physician providing the telehealth

220.22 consultation; and

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

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

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

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

56.24 (2) "health care provider" means a health care provider as defined under section 62A.673;
56.25 a community paramedic as defined under section 144E.001, subdivision 5f; a community
56.26 health worker who meets the criteria under subdivision 49, paragraph (a); a mental health
56.27 certified peer specialist under section 245I.04, subdivision 10; a mental health certified
56.28 family peer specialist under section 245I.04, subdivision 12; a mental health rehabilitation
56.29 worker under section 245I.04, subdivision 14; a mental health behavioral aide under section
56.30 245I.04, subdivision 16; a treatment coordinator under section 245G.11, subdivision 7; an
56.31 alcohol and drug counselor under section 245G.11, subdivision 5; or a recovery peer under
56.32 section 245G.11, subdivision 8; and

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

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

57.2 Sec. 10. Minnesota Statutes 2024, section 256B.0625, subdivision 17, is amended to read:

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

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

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

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

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

221.11 (2) "health care provider" means a health care provider as defined under section 62A.673;
221.12 a community paramedic as defined under section 144E.001, subdivision 5f; a community
221.13 health worker who meets the criteria under subdivision 49, paragraph (a); a mental health
221.14 certified peer specialist under section 245I.04, subdivision 10; a mental health certified
221.15 family peer specialist under section 245I.04, subdivision 12; a mental health rehabilitation
221.16 worker under section 245I.04, subdivision 14; a mental health behavioral aide under section
221.17 245I.04, subdivision 16; a treatment coordinator under section 245G.11, subdivision 7; an
221.18 alcohol and drug counselor under section 245G.11, subdivision 5; or a recovery peer under
221.19 section 245G.11, subdivision 8; and

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

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

57.7 (b) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
57.8 a census-tract based classification system under which a geographical area is determined
57.9 to be urban, rural, or super rural. This paragraph expires July 1, 2026, for medical assistance
57.10 fee-for-service and January 1, 2027, for prepaid medical assistance.

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

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

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

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

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

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

57.24 (d) Medical assistance covers nonemergency medical transportation provided by
57.25 nonemergency medical transportation providers enrolled in the Minnesota health care
57.26 programs. All nonemergency medical transportation providers must comply with the
57.27 operating standards for special transportation service as defined in sections 174.29 to 174.30
57.28 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
57.29 commissioner and reported on the claim as the individual who provided the service. All
57.30 nonemergency medical transportation providers shall bill for nonemergency medical
57.31 transportation services in accordance with Minnesota health care programs criteria. Publicly
58.1 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
58.2 requirements outlined in this paragraph.

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

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

58.6 (2) the provider has initiated background studies on the individuals specified in section
58.7 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

- 58.12 (f) The administrative agency of nonemergency medical transportation must:
- 58.13 (1) adhere to the policies defined by the commissioner;
- 58.14 (2) pay nonemergency medical transportation providers for services provided to
- 58.15 Minnesota health care programs beneficiaries to obtain covered medical services;
- 58.16 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
- 58.17 trips, and number of trips by mode; and
- 58.18 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
- 58.19 administrative structure assessment tool that meets the technical requirements established
- 58.20 by the commissioner, reconciles trip information with claims being submitted by providers,
- 58.21 and ensures prompt payment for nonemergency medical transportation services. This
- 58.22 paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027,
- 58.23 for prepaid medical assistance.
- 58.24 (g) Effective July 1, 2026, for medical fee-for-service and January 1, 2027, for prepaid
- 58.25 medical assistance, the administrative agency of nonemergency medical transportation must:
- 58.26 (1) adhere to the policies defined by the commissioner;
- 58.27 (2) pay nonemergency medical transportation providers for services provided to
- 58.28 Minnesota health care program beneficiaries to obtain covered medical services; and
- 58.29 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
- 58.30 trips, and number of trips by mode.
- 59.1 ~~(g)~~ (h) Until the commissioner implements the single administrative structure and delivery
- 59.2 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
- 59.3 commissioner or an entity approved by the commissioner that does not dispatch rides for
- 59.4 clients using modes of transportation under paragraph ~~(h)~~ (n), clauses (4), (5), (6), and (7).
- 59.5 This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1,
- 59.6 2027, for prepaid medical assistance.
- 59.7 ~~(h)~~ (i) The commissioner may use an order by the recipient's attending physician,
- 59.8 advanced practice registered nurse, physician assistant, or a medical or mental health
- 59.9 professional to certify that the recipient requires nonemergency medical transportation
- 59.10 services. Nonemergency medical transportation providers shall perform driver-assisted
- 59.11 services for eligible individuals, when appropriate. Driver-assisted service includes passenger
- 59.12 pickup at and return to the individual's residence or place of business, assistance with
- 59.13 admittance of the individual to the medical facility, and assistance in passenger securement
- 59.14 or in securing of wheelchairs, child seats, or stretchers in the vehicle.
- 59.15 ~~(i)~~ (j) Nonemergency medical transportation providers must take clients to the health
- 59.16 care provider using the most direct route, and must not exceed 30 miles for a trip to a primary
- 59.17 care provider or 60 miles for a trip to a specialty care provider, unless the client receives

59.18 authorization from the local agency. This paragraph expires July 1, 2026, for medical
59.19 assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

59.20 (k) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027,
59.21 for prepaid medical assistance, nonemergency medical transportation providers must take
59.22 clients to the health care provider using the most direct route and must not exceed 30 miles
59.23 for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless
59.24 the client receives authorization from the administrator.

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

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

60.3 (n) The covered modes of transportation are:

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

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

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

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

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

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

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

60.25 ~~(m)~~ (o) The local agency shall be the single administrative agency and shall administer
60.26 and reimburse for modes defined in paragraph ~~(h)~~ (n) according to paragraphs ~~(p)~~ and ~~(q)~~
60.27 (r) to (t) when the commissioner has developed, made available, and funded the web-based
60.28 single administrative structure, assessment tool, and level of need assessment under
60.29 subdivision 18e. The local agency's financial obligation is limited to funds provided by the
60.30 state or federal government. This paragraph expires July 1, 2026, for medical assistance
60.31 fee-for-service and January 1, 2027, for prepaid medical assistance.

60.32 ~~(n)~~ (p) The commissioner shall:

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

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

61.3 (3) investigate all complaints and appeals.

61.4 ~~(o)~~ (q) The administrative agency shall pay for the services provided in this subdivision
61.5 and seek reimbursement from the commissioner, if appropriate. As vendors of medical care,
61.6 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
61.7 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.
61.8 This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1,
61.9 2027, for prepaid medical assistance.

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

61.15 (1) \$0.22 per mile for client reimbursement;

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

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

61.21 (4) \$14.30 for the base rate and \$1.43 per mile for assisted transport;

61.22 (5) \$19.80 for the base rate and \$1.70 per mile for lift-equipped/ramp transport;

61.23 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

61.24 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
61.25 an additional attendant if deemed medically necessary. This paragraph expires July 1, 2026,
61.26 for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

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

61.31 ~~(t)~~ (t) The base rate for nonemergency medical transportation services in areas defined
61.32 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
62.1 paragraph ~~(r)~~ (r), clauses (1) to (7). The mileage rate for nonemergency medical
62.2 transportation services in areas defined under RUCA to be rural or super rural areas is:

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

62.5 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
62.6 rate in paragraph ~~(r)~~ (r), clauses (1) to (7). This paragraph expires July 1, 2026, for medical
62.7 assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

62.8 ~~(u)~~ (u) For purposes of reimbursement rates for nonemergency medical transportation
62.9 services under paragraphs ~~(p)~~ and ~~(q)~~ (r) to (t), the zip code of the recipient's place of
62.10 residence shall determine whether the urban, rural, or super rural reimbursement rate applies.
62.11 This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1,
62.12 2027, for prepaid medical assistance.

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

62.16 ~~(w)~~ (w) Effective for the first day of each calendar quarter in which the price of gasoline
62.17 as posted publicly by the United States Energy Information Administration exceeds \$3.00
62.18 per gallon, the commissioner shall adjust the rate paid per mile in paragraph ~~(r)~~ (r) by one
62.19 percent up or down for every increase or decrease of ten cents for the price of gasoline. The
62.20 increase or decrease must be calculated using a base gasoline price of \$3.00. The percentage
62.21 increase or decrease must be calculated using the average of the most recently available
62.22 price of all grades of gasoline for Minnesota as posted publicly by the United States Energy
62.23 Information Administration. This paragraph expires July 1, 2026, for medical assistance
62.24 fee-for-service and January 1, 2027, for prepaid medical assistance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

64.3 Subd. 18i. Administration of nonemergency medical transportation. Effective July
64.4 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical
64.5 assistance, the commissioner must contract either statewide or regionally for the
64.6 administration of the nonemergency medical transportation program in compliance with
64.7 the provisions of this chapter. The contract must include the administration of the
64.8 nonemergency medical transportation benefit for those enrolled in managed care as described
64.9 in section 256B.69.

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

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

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

223.6 Subd. 25c. Applicability of utilization review provisions. (a) Effective January 1,
223.7 2026, the following provisions of chapter 62M apply to the commissioner when delivering
223.8 services under chapters 256B and 256L: 62M.02, subdivisions 1 to 5, 7 to 12, 13, 14 to 18,
223.9 and 21; 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions 1 to 3; 62M.07;
223.10 62M.072; 62M.09; 62M.10; 62M.12; and 62M.17, subdivision 2; and 62M.18.

223.11 (b) By April 1, 2026, and each April 1 thereafter, managed care plans and county-based
223.12 purchasing plans when the plan is providing coverage to enrollees under chapter 256B or
223.13 256L, and the commissioner when delivering services under chapters 256B and 256L, must
223.14 post on the entity's public website the following data for the immediately preceding calendar
223.15 year for each health plan or program:

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

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

223.19 (i) health care service;

223.20 (ii) whether the adverse determination was appealed; and

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

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

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

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

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

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

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

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

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

223.27 (iii) a change in treatment program; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 67.15 (i) general social services and administrative costs;
- 67.16 (ii) retail pharmacy;
- 67.17 (iii) patient incentives, food, housing assistance, and utility assistance;
- 67.18 (iv) external lab and x-ray;
- 67.19 (v) navigation services;
- 67.20 (vi) health care taxes;
- 67.21 (vii) advertising, public relations, and marketing;
- 67.22 (viii) office entertainment costs, food, alcohol, and gifts;
- 67.23 (ix) contributions and donations;
- 67.24 (x) bad debts or losses on awards or contracts;
- 67.25 (xi) fines, penalties, damages, or other settlements;
- 67.26 (xii) fundraising, investment management, and associated administrative costs;
- 67.27 (xiii) research and associated administrative costs;
- 67.28 (xiv) nonpaid workers;
- 67.29 (xv) lobbying;
- 68.1 (xvi) scholarships and student aid; and
- 68.2 (xvii) nonmedical assistance covered services;

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

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

- 68.9 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports
68.10 from 2017 and 2018;
- 68.11 (ii) must be according to current applicable Medicare cost principles as applicable to
68.12 FQHCs and rural health clinics without the application of productivity screens and upper
68.13 payment limits or the Medicare prospective payment system FQHC aggregate mean upper
68.14 payment limit;

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

- 227.8 (i) general social services and administrative costs;
- 227.9 (ii) retail pharmacy;
- 227.10 (iii) patient incentives, food, housing assistance, and utility assistance;
- 227.11 (iv) external lab and x-ray;
- 227.12 (v) navigation services;
- 227.13 (vi) health care taxes;
- 227.14 (vii) advertising, public relations, and marketing;
- 227.15 (viii) office entertainment costs, food, alcohol, and gifts;
- 227.16 (ix) contributions and donations;
- 227.17 (x) bad debts or losses on awards or contracts;
- 227.18 (xi) fines, penalties, damages, or other settlements;
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- 227.20 (xiii) research and associated administrative costs;
- 227.21 (xiv) nonpaid workers;
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227.28 publish the list and any updates in the Minnesota health care programs provider manual;

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228.2 health clinics shall be computed for services delivered on or after January 1, 2021, and:

- 228.3 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports
228.4 from 2017 and 2018;
- 228.5 (ii) must be according to current applicable Medicare cost principles as applicable to
228.6 FQHCs and rural health clinics without the application of productivity screens and upper
228.7 payment limits or the Medicare prospective payment system FQHC aggregate mean upper
228.8 payment limit;

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

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

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

68.25 (6) the commissioner shall annually inflate the applicable organization encounter rates
68.26 for FQHCs and rural health clinics from the base year payment rate to the effective date by
68.27 using the CMS FQHC Market Basket inflator established under United States Code, title
68.28 42, section 1395m(o), less productivity;

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

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

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

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

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

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

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

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

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

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

228.19 (6) the commissioner shall annually inflate the applicable organization encounter rates
228.20 for FQHCs and rural health clinics from the base year payment rate to the effective date by
228.21 using the CMS FQHC Market Basket inflator established under United States Code, title
228.22 42, section 1395m(o), less productivity;

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

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

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

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

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

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

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

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

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

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

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

70.12 ~~(13)~~ (14) the commissioner shall establish a quality measures workgroup that includes
70.13 representatives from the Minnesota Association of Community Health Centers, FQHCs,
70.14 and rural health clinics, to evaluate clinical and nonclinical measures; and

70.15 ~~(14)~~ (15) the commissioner shall not disallow or reduce costs that are related to an
70.16 FQHC's or rural health clinic's participation in health care educational programs to the extent
70.17 that the costs are not accounted for in the alternative payment methodology encounter rate
70.18 established in this paragraph.

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

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

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

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

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

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230.9 representatives from the Minnesota Association of Community Health Centers, FQHCs,
230.10 and rural health clinics, to evaluate clinical and nonclinical measures; and

230.11 ~~(14)~~ (15) the commissioner shall not disallow or reduce costs that are related to an
230.12 FQHC's or rural health clinic's participation in health care educational programs to the extent
230.13 that the costs are not accounted for in the alternative payment methodology encounter rate
230.14 established in this paragraph.

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230.16 center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC.
230.17 Requirements that otherwise apply to an FQHC covered in this subdivision do not apply to
230.18 a Tribal FQHC enrolled under this paragraph, except that any requirements necessary to
230.19 comply with federal regulations do apply to a Tribal FQHC. The commissioner shall establish
230.20 an alternative payment method for a Tribal FQHC enrolled under this paragraph that uses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

71.7 Subd. 5. **Commissioner's duties; state-directed fee schedule requirement.** (a) For

71.8 each federally approved directed payment arrangement that is a state-directed fee schedule

233.31 individual under subdivision 2 that selects the health home as a provider. This paragraph

233.32 expires on the date that paragraph (b) becomes effective.

234.1 (b) Effective January 1, 2028, or upon federal approval, whichever is later, the

234.2 commissioner shall make payments to each designated provider for the provision of health

234.3 home services described in subdivision 3, except for behavioral health services, to each

234.4 eligible individual under subdivision 2 who selects the health home as a provider.

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

234.6 to read:

234.7 Subd. 5a. **Payments for behavioral health home services.** (a) Notwithstanding

234.8 subdivision 5, the commissioner must implement a single statewide reimbursement rate for

234.9 behavioral health home services under this section. The rate must be no less than \$425 per

234.10 member per month. The commissioner must adjust the reimbursement rate for behavioral

234.11 health home services annually according to the change from the midpoint of the previous

234.12 rate year to the midpoint of the rate year for which the rate is being determined using the

234.13 Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in

234.14 the fourth quarter of the calendar year before the rate year.

234.15 (b) The commissioner must review and update the behavioral health home services rate

234.16 under paragraph (a) at least every four years. The updated rate must account for the average

234.17 hours required for behavioral health home team members spent providing services and the

234.18 Department of Labor prevailing wage for required behavioral health home team members.

234.19 The updated rate must ensure that behavioral health home services rates are sufficient to

234.20 allow providers to meet required certifications, training, and practice transformation

234.21 standards; staff qualification requirements; and service delivery standards.

234.22 (c) Managed care plans and county-based purchasing plans must reimburse providers

234.23 at an amount that is at least equal to the fee-for-service rate for services under this

234.24 subdivision. The commissioner must monitor the effect of this rate increase on enrollee

234.25 access to services under this subdivision. If for any contract year federal approval is not

234.26 received for this paragraph, the commissioner must adjust the capitation rates paid to managed

234.27 care plans and county-based purchasing plans for that contract year to reflect the removal

234.28 of this paragraph. Contracts between managed care plans and county-based purchasing

234.29 plans and providers to whom this paragraph applies must allow recovery of payments from

234.30 those providers if capitation rates are adjusted in accordance with this paragraph. Payment

234.31 recoveries must not exceed the amount equal to any increase in rates that results from this

234.32 paragraph.

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

234.34 is later.

71.9 requirement, the commissioner shall determine a uniform adjustment factor to be applied
71.10 to each claim submitted by an eligible provider to a health plan. The uniform adjustment
71.11 factor shall be determined using the average commercial payer rate or using another method
71.12 acceptable to the Centers for Medicare and Medicaid Services if the average commercial
71.13 payer rate is not approved, minus the amount necessary for the plan to satisfy tax liabilities
71.14 under sections 256.9657 and 2971.05 attributable to the directed payment arrangement. The
71.15 commissioner shall ensure that the application of the uniform adjustment factor maximizes
71.16 the allowable directed payments and does not result in payments exceeding federal limits,
71.17 and may use an annual settle-up process. The directed payment ~~shall~~ may be specific to
71.18 each health plan and prospectively incorporated into capitation payments for that plan.

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

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

71.29 Subd. 9. **Interaction with other directed payments.** An eligible provider under
71.30 subdivision 3 may participate in the hospital directed payment program under section
71.31 256B.1974 for inpatient hospital services, outpatient hospital services, or both. A provider
71.32 participating in the hospital directed payment program must not receive a directed payment
71.33 under this section for any provider classes paid via the hospital directed payment program.
72.1 A hospital subject to this section must notify the commissioner in writing no later than 30
72.2 days after enactment of this subdivision of its intention to participate in the hospital directed
72.3 payment program under section 256B.1974 for inpatient hospital services, outpatient hospital
72.4 services, or both. The election under this subdivision is a onetime election, except that if
72.5 an eligible provider elects to participate in the hospital directed payment program, and the
72.6 hospital directed payment program expires, then the eligible provider may thereafter elect
72.7 to participate in the directed payment under this section.

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

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

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

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

235.3 Subd. 9. **Interaction with other directed payments.** An eligible provider under
235.4 subdivision 3 may participate in the hospital directed payment program under section
235.5 256B.1974 for inpatient hospital services, outpatient hospital services, or both. A provider
235.6 participating in the hospital directed payment program must not receive a directed payment
235.7 under this section for any provider classes paid via the hospital directed payment program.
235.8 A hospital subject to this section must notify the commissioner in writing no later than 30
235.9 days after enactment of this subdivision of its intention to participate in the hospital directed
235.10 payment program under section 256B.1974 for inpatient hospital services, outpatient hospital
235.11 services, or both. The election under this subdivision is a onetime election, except that if
235.12 an eligible provider elects to participate in the hospital directed payment program, and the
235.13 hospital directed payment program expires, then the eligible provider may thereafter elect
235.14 to participate in the directed payment ~~program~~ under this section.

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

235.17 (1) this section;

235.18 (2) the amendments in this act to add Minnesota Statutes, section 256.9657, subdivision
235.19 2b; and

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

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

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

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

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

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

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

72.27 Subd. 3. **Commissioner's duties; state-directed fee schedule requirement.** (a) For
72.28 each federally approved directed payment program that is a state-directed fee schedule
72.29 requirement that includes a quarterly payment amount to be submitted by each health plan
72.30 to each eligible hospital, the commissioner must determine the quarterly payment amount
72.31 using the statewide average commercial payer rate, or using another method acceptable to
72.32 the Centers for Medicare and Medicaid Services if the statewide average commercial payer
73.1 rate is not approved. The commissioner must ensure that the application of the quarterly
73.2 payment amounts maximizes the amount generated by the hospital assessment in section
73.3 256.9657, subdivision 2b, for allowable directed payments and does not result in payments
73.4 exceeding federal limits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

74.13 (l) The commissioner must distribute payments required under this section for each
74.14 eligible hospital within 30 days of a quarterly assessment under section 256.9657, subdivision
74.15 2b, being received. The commissioner must pay the directed payments to health plans under
74.16 contract no later than January 1, April 1, July 1, and October 1 each year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

75.6 (b) Health plans are prohibited from:

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

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

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

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

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

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

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

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

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

238.17 (b) Health plans are prohibited from:

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

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

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

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

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

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

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

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

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

75.30 (1) overall well child visit rates;
75.31 (2) maternal depression screening rates; or
75.32 (3) colon cancer screening rates.

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

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

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

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

76.16 (1) the amendments in this act adding Minnesota Statutes, section 256.9657, subdivision
76.17 2b; and
76.18 (2) the amendments in this act to this section.

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

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

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

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

239.8 (1) overall well child visit rates;
239.9 (2) maternal depression screening rates; or
239.10 (3) colon cancer screening rates.

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

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

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

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

239.26 (1) the amendments in this act to add Minnesota Statutes, section 256.9657, subdivision
239.27 2b; and
239.28 (2) the amendments in this act to this section.

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

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

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

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

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

76.28 Subd. 2. **Reports to the legislature.** By January 15, 2027, and each January 15 thereafter,
76.29 the commissioner must submit a report to the chairs and ranking minority members of the
76.30 legislative committees with jurisdiction over health and human services policy and finance
76.31 that details the activities and uses of money in the hospital directed payment program
77.1 account, including the metrics and outcomes of the policy goals established by section
77.2 256B.1974, subdivision 7.

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

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

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

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

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

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

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

240.8 Subd. 2. **Reports to the legislature.** By January 15, 2027, and each January 15 thereafter,
240.9 the commissioner must submit a report to the chairs and ranking minority members of the
240.10 legislative committees with jurisdiction over health and human services policy and finance
240.11 that details the activities and uses of money in the hospital directed payment program
240.12 account, including the metrics and outcomes of the policy goals established by section
240.13 256B.1974, subdivision 7.

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

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

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

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

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

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

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

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

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

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

79.12 ~~(h)~~ (i) The commissioner shall provide a written report under section 3.195 to the chairs
79.13 of the legislative committees having jurisdiction over human services in the senate and the
79.14 house of representatives describing in detail the activities undertaken by the commissioner
79.15 to ensure full compliance with this section. The report must also provide an explanation for
79.16 any decisions of the commissioner not to accept the recommendations of a county or group
79.17 of counties required to be consulted under this section. The report must be provided at least
79.18 30 days prior to the effective date of a new or renewed prepaid or managed care contract
79.19 in a county.

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

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

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

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

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

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

79.29 (1) residing in a county administering CARMA; and

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

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

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

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

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

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

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

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

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

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

80.18 Subd. 4. **Oversight and regulation.** CARMA is governed by sections 256B.69 and
80.19 256B.692, unless otherwise provided for under this section. The commissioner must develop
80.20 and implement a procurement process requiring applications from county-based purchasing
80.21 plans interested in offering CARMA. The procurement process must require county-based
80.22 purchasing plans to demonstrate compliance with federal and state regulatory requirements
80.23 and the ability to meet the goals of the program set forth in subdivision 2. The commissioner
80.24 must review and approve or disapprove applications.

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

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

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

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

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

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

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

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

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

81.27 (b) Counties or groups of counties administering CARMA may include health-related
 81.28 social needs (HRSN) benefits as covered services under medical assistance as of January
 81.29 1, 2030. Coverage for HRSN must be based on the assessed needs of housing, food,
 81.30 transportation, utilities, and interpersonal safety.

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

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

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

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

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

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

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

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

82.22 (b) Payments for benefits and services under subdivision 6, paragraph (a), must not
82.23 exceed payments that otherwise would have been paid to health plans under medical
82.24 assistance for that county or region. Payments for HRSN benefits under subdivision 6,
82.25 paragraph (b), must be in addition to payments for benefits and services under subdivision
82.26 6, paragraph (a).

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

82.31 (1) enrollee experience and outcomes;

82.32 (2) population health;

83.1 (3) health equity; and

83.2 (4) the value of health care spending.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

241.7 (c) Effective for services rendered on or after July 1, 2009, payment rates for physician
241.8 and professional services shall be reduced by five percent, except that for the period July
241.9 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical
241.10 assistance and general assistance medical care programs, over the rates in effect on June
241.11 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other
241.12 outpatient visits, preventive medicine visits and family planning visits billed by physicians,
241.13 advanced practice registered nurses, or physician assistants in a family planning agency or
241.14 in one of the following primary care practices: general practice, general internal medicine,
241.15 general pediatrics, general geriatrics, and family medicine. This reduction and the reductions
241.16 in paragraph (d) do not apply to federally qualified health centers, rural health centers, and
241.17 Indian health services. Effective October 1, 2009, payments made to managed care plans
241.18 and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall
241.19 reflect the payment reduction described in this paragraph.

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

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

241.33 (f) Effective for services rendered on or after September 1, 2014, payment rates for
241.34 physician and professional services, including physical therapy, occupational therapy, speech
242.1 pathology, and mental health services shall be increased by five percent from the rates in
242.2 effect on August 31, 2014. In calculating this rate increase, the commissioner shall not
242.3 include in the base rate for August 31, 2014, the rate increase provided under section
242.4 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,
242.5 rural health centers, and Indian health services. Payments made to managed care plans and
242.6 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

242.7 ~~(g)~~ (a) Effective for services rendered on or after July 1, 2015, payment rates for physical
242.8 therapy, occupational therapy, and speech pathology and related services provided by a
242.9 hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause
242.10 (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments
242.11 made to managed care plans and county-based purchasing plans shall not be adjusted to
242.12 reflect payments under this paragraph.

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

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

242.20 **EFFECTIVE DATE.** This section is effective January 1, 2026, or upon federal approval
242.21 of the amendments in this act to Minnesota Statutes, sections 256B.76, subdivision 6, and
242.22 256B.768, whichever is later. The commissioner of human services shall notify the revisor
242.23 of statutes when federal approval is obtained.

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

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

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

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

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

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

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

243.20 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

243.21 Subdivision 1. **Rates effective 2026.** ~~(a) Effective for services rendered on or after July~~
243.22 ~~1, 2001, payment for medication management provided to psychiatric patients, outpatient~~
243.23 ~~mental health services, day treatment services, home-based mental health services, and~~
243.24 ~~family community support services shall be paid at the lower of (1) submitted charges, or~~
243.25 ~~(2) 75.6 percent of the 50th percentile of 1999 charges.~~

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

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

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

244.10 ~~(e) Effective for services rendered on or after January 1, 2024, payment rates for~~
244.11 ~~behavioral health services included in the rate analysis required by Laws 2021, First Special~~
244.12 ~~Session chapter 7, article 17, section 18, except for adult day treatment services under section~~
244.13 ~~256B.0671, subdivision 3; early intensive developmental and behavioral intervention services~~
244.14 ~~under section 256B.0949; and substance use disorder services under chapter 254B, must be~~
244.15 ~~increased by three percent from the rates in effect on December 31, 2023. Effective for~~
244.16 ~~services rendered on or after January 1, 2025, payment rates for behavioral health services~~
244.17 ~~included in the rate analysis required by Laws 2021, First Special Session chapter 7, article~~
244.18 ~~17, section 18; early intensive developmental behavioral intervention services under section~~

244.19 ~~256B.0949; and substance use disorder services under chapter 254B, must be annually~~
244.20 ~~adjusted according to the change from the midpoint of the previous rate year to the midpoint~~
244.21 ~~of the rate year for which the rate is being determined using the Centers for Medicare and~~
244.22 ~~Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the~~
244.23 ~~calendar year before the rate year. For payments made in accordance with this paragraph,~~
244.24 ~~if and to the extent that the commissioner identifies that the state has received federal~~
244.25 ~~financial participation for behavioral health services in excess of the amount allowed under~~
244.26 ~~United States Code, title 42, section 447.321, the state shall repay the excess amount to the~~
244.27 ~~Centers for Medicare and Medicaid Services with state money and maintain the full payment~~
244.28 ~~rate under this paragraph. This paragraph does not apply to federally qualified health centers,~~
244.29 ~~rural health centers, Indian health services, certified community behavioral health clinics,~~
244.30 ~~cost-based rates, and rates that are negotiated with the county. This paragraph expires upon~~
244.31 ~~legislative implementation of the new rate methodology resulting from the rate analysis~~
244.32 ~~required by Laws 2021, First Special Session chapter 7, article 17, section 18.~~

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

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

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

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

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

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

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

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

- 245.21 (2) the payment rates in effect on December 31, 2025.
- 245.22 Subd. 2. **Rates effective 2027.** (a) Effective for services rendered on or after January 1,
- 245.23 2027, the commissioner must establish market-based payment rates for the following services:
- 245.24 (1) adult day treatment services under section 256B.0671, subdivision 3;
- 245.25 (2) adult rehabilitative mental health services under section 256B.0623;
- 245.26 (3) adult mental health peer support specialist services under section 256B.0615;
- 245.27 (4) dialectical behavioral therapy under section 256B.0671, subdivision 6;
- 245.28 (5) explanation of findings under section 256B.0671, subdivision 4;
- 245.29 (6) mental health crisis response services under section 256B.0624;
- 245.30 (7) mental health provider travel time under section 256B.0625, subdivision 43;
- 246.1 (8) neuropsychological testing under section 256B.0671, subdivision 9;
- 246.2 (9) partial hospitalization services under section 256B.0671, subdivision 12; and
- 246.3 (10) psychotherapy services under section 256B.0671, subdivision 11, incorporating
- 246.4 biofeedback.
- 246.5 (b) Rates established under paragraph (a) must not be lower than:
- 246.6 (1) the payments rates recommended in the rate analysis required by Laws 2021, First
- 246.7 Special Session chapter 7, article 17, section 18, and published by the Department of Human
- 246.8 Services on January 22, 2024; or
- 246.9 (2) the payment rates in effect on December 31, 2026.
- 246.10 Subd. 3. **Capitation payments.** The commissioner must adjust capitation payments
- 246.11 made to managed care plans and county-based purchasing plans to reflect the behavioral
- 246.12 health service rates provided in this section. Managed care and county-based purchasing
- 246.13 plans must reimburse providers at an amount that is at least equal to the fee-for-service rate
- 246.14 for services under this section. The commissioner must monitor the effect of this rate
- 246.15 adjustment on enrollee access to behavioral health services. If for any contract year federal
- 246.16 approval is not received for this subdivision, the commissioner must adjust the capitation
- 246.17 rates paid to managed care plans and county-based purchasing plans for that contract year
- 246.18 to reflect the removal of this provision. Contracts between managed care plans and
- 246.19 county-based purchasing plans and providers to whom this subdivision applies must allow
- 246.20 recovery of payments from those providers if capitation rates are adjusted in accordance
- 246.21 with this subdivision. Payment recoveries must not exceed the amount equal to any increase
- 246.22 in rates that results from this subdivision.
- 246.23 Subd. 4. **Inflation adjustment.** The commissioner must adjust the reimbursement rate
- 246.24 for services under this section annually according to the change from the midpoint of the

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

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

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

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

247.4 Sec. 19. Minnesota Statutes 2024, section 256B.766, is amended to read:

247.5 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

247.6 Subdivision 1. **Payment reductions for base care services effective July 1, 2009.** ~~(a)~~
247.7 Effective for services provided on or after July 1, 2009, total payments for basic care services,
247.8 shall be reduced by three percent, except that for the period July 1, 2009, through June 30,
247.9 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general
247.10 assistance medical care programs, prior to third-party liability and spenddown calculation.

247.11 Subd. 2. **Classification of therapies as basic care services.** Effective July 1, 2010, The
247.12 commissioner shall classify physical therapy services, occupational therapy services, and
247.13 speech-language pathology and related services as basic care services. The reduction in this
247.14 paragraph subdivision 1 shall apply to physical therapy services, occupational therapy
247.15 services, and speech-language pathology and related services provided on or after July 1,
247.16 2010.

247.17 Subd. 3. **Payment reductions to managed care plans effective October 1, 2009.** ~~(b)~~
247.18 Payments made to managed care plans and county-based purchasing plans shall be reduced
247.19 for services provided on or after October 1, 2009, to reflect the reduction in subdivision 1
247.20 effective July 1, 2009, and payments made to the plans shall be reduced effective October
247.21 1, 2010, to reflect the reduction in subdivision 1 effective July 1, 2010.

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

247.26 ~~(a)~~ (b) Effective for services provided on or after September 1, 2011, through June 30,
247.27 2013, total payments for ambulatory surgery centers facility fees, medical supplies and
247.28 durable medical equipment not subject to a volume purchase contract, prosthetics and
247.29 orthotics, renal dialysis services, laboratory services, public health nursing services, physical
247.30 therapy services, occupational therapy services, speech therapy services, eyeglasses not

247.31 subject to a volume purchase contract, hearing aids not subject to a volume purchase contract,
247.32 and anesthesia services shall be reduced by three percent from the rates in effect on August
247.33 31, 2011.

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

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

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

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

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

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

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

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

248.32 (b) This ~~paragraph~~ subdivision does not apply to medical supplies and durable medical
248.33 equipment subject to a volume purchase contract, products subject to the preferred diabetic

249.1 testing supply program, and items provided to dually eligible recipients when Medicare is
249.2 the primary payer for the item.

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

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

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

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

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

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

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

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

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

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

250.6 Subd. 13. **Temporary rates for enteral nutrition and supplies.** ~~(m)~~ (a) For dates of
250.7 service on or after July 1, 2023, through June 30, 2025, enteral nutrition and supplies must
250.8 be paid according to this ~~paragraph~~ subdivision. If sufficient data exists for a product or
250.9 supply, payment must be based upon the 50th percentile of the usual and customary charges
250.10 per product code submitted to the commissioner, using only charges submitted per unit.
250.11 Increases in rates resulting from the 50th percentile payment method must not exceed 150
250.12 percent of the previous fiscal year's rate per code and product combination. Data are sufficient
250.13 if: (1) the commissioner has at least 100 paid claim lines by at least ten different providers
250.14 for a given product or supply; or (2) in the absence of the data in clause (1), the commissioner
250.15 has at least 20 claim lines by at least five different providers for a product or supply that
250.16 does not meet the requirements of clause (1). If sufficient data are not available to calculate
250.17 the 50th percentile for enteral products or supplies, the payment rate must be the payment
250.18 rate in effect on June 30, 2023.

250.19 (b) This subdivision expires June 30, 2025.

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

251.1 Subd. 15. **Rates for phototherapy services.** For dates of service on or after July 1,
251.2 2025, the payment rate for phototherapy services provided to newborns in the home setting
251.3 must include a service fee in the amount of \$520 per patient episode, in addition to the daily
251.4 rental rate for the medical equipment in subdivision 12. The commissioner shall provide an
251.5 annual inflation adjustment for the phototherapy service fee. The index for the inflation
251.6 adjustment must be based on the Consumer Price Index for All Urban Consumers increase
251.7 published by the Bureau of Labor Statistics.

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

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

- 251.11 January 1, 2026, or the date of federal approval, whichever is later, the commissioner must
251.12 make payments based on the resource-based relative value scale for all services:
- 251.13 (1) covered in medical assistance; and
251.14 (2) with a corresponding rate and procedure code in the Medicare Physician Fee Schedule.
- 251.15 (b) Effective January 1, 2026, or upon federal approval, whichever is later, and effective
251.16 for services rendered on or after January 1, 2026, or the date of federal approval, whichever
251.17 is later, rates must be at least equal to 100 percent of the Medicare Physician Fee Schedule
251.18 if the service:
- 251.19 (1) is reimbursed in medical assistance under the resource-based relative value scale;
251.20 and
251.21 (2) has a corresponding rate and procedural code in the Medicare Physician Fee Schedule.
- 251.22 (c) For services rendered on or after January 1, 2026, the commissioner shall increase
251.23 capitation payments made to managed care plans and county-based purchasing plans to
251.24 reflect the rate increases provided under this subdivision. Managed care plans and
251.25 county-based purchasing plans must reimburse providers at an amount that is at least equal
251.26 to the fee-for-service rate for services under this subdivision. The commissioner must
251.27 monitor the effect of this rate increase on enrollee access to services under this subdivision.
251.28 If for any contract year federal approval is not received for this paragraph, the commissioner
251.29 must adjust the capitation rates paid to managed care plans and county-based purchasing
251.30 plans for that contract year to reflect the removal of this paragraph. Contracts between
251.31 managed care plans and county-based purchasing plans and providers to whom this paragraph
251.32 applies must allow recovery of payments from those providers if capitation rates are adjusted
252.1 in accordance with this paragraph. Payment recoveries must not exceed the amount equal
252.2 to any increase in rates that results from this paragraph.
- 252.3 Subd. 2. **Applicable fee schedule.** For purposes of this section, the applicable Medicare
252.4 Physician Fee Schedule is the most recent Medicare Physician Fee Schedule Final Rule
252.5 issued by the Centers for Medicare and Medicaid Services in effect at the time the service
252.6 was rendered.
- 252.7 Subd. 3. **Exceptions.** This section does not apply to federally qualified health centers,
252.8 rural health centers, Indian health services, certified community behavioral health clinics,
252.9 cost-based rates, and rates that are negotiated with the county.
- 252.10 **EFFECTIVE DATE.** This section is effective January 1, 2026, or upon federal approval,
252.11 whichever is later. The commissioner of human services shall notify the revisor of statutes
252.12 when federal approval is obtained.
- 252.13 Sec. 21. Minnesota Statutes 2024, section 295.50, subdivision 3, is amended to read:
- 252.14 Subd. 3. **Gross revenues.** (a) "Gross revenues" are total amounts received in money or
252.15 otherwise by:

- 252.16 (1) a hospital for patient services;
- 252.17 (2) a surgical center for patient services;
- 252.18 (3) a health care provider, other than a staff model health plan company, for patient
- 252.19 services;
- 252.20 (4) a wholesale drug distributor for sale or distribution of legend drugs that are delivered
- 252.21 in Minnesota by the wholesale drug distributor, by common carrier, or by mail, unless the
- 252.22 legend drugs are delivered to another wholesale drug distributor who sells legend drugs
- 252.23 exclusively at wholesale; and
- 252.24 (5) a staff model health plan company as gross premiums for enrollees, co-payments,
- 252.25 deductibles, coinsurance, and fees for patient services.
- 252.26 (b) For purposes of paragraph (a), clause (4), "gross revenues" includes the amount of
- 252.27 any rebate provided by the wholesale drug distributor to a customer, however provided,
- 252.28 including a rebate provided under a contractual obligation. "Rebate" means any price
- 252.29 concession provided by a wholesale drug distributor, including any price concession based
- 252.30 on the actual or estimated utilization, sale volume, or effectiveness of a legend drug.
- 252.31 **EFFECTIVE DATE.** This section is effective for gross revenues received after June
- 252.32 30, 2025.
- 253.1 Sec. 22. Minnesota Statutes 2024, section 295.52, subdivision 1, is amended to read:
- 253.2 Subdivision 1. **Hospital tax.** A tax is imposed on each hospital equal to ~~1.8~~ two percent
- 253.3 of its gross revenues.
- 253.4 **EFFECTIVE DATE.** This section is effective for gross revenues received after June
- 253.5 30, 2025.
- 253.6 Sec. 23. Minnesota Statutes 2024, section 295.52, subdivision 1a, is amended to read:
- 253.7 Subd. 1a. **Surgical center tax.** A tax is imposed on each surgical center equal to ~~1.8~~
- 253.8 two percent of its gross revenues.
- 253.9 **EFFECTIVE DATE.** This section is effective for gross revenues received after June
- 253.10 30, 2025.
- 253.11 Sec. 24. Minnesota Statutes 2024, section 295.52, subdivision 2, is amended to read:
- 253.12 Subd. 2. **Provider tax.** A tax is imposed on each health care provider equal to ~~1.8~~ two
- 253.13 percent of its gross revenues.
- 253.14 **EFFECTIVE DATE.** This section is effective for gross revenues received after June
- 253.15 30, 2025.

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

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

253.19 **EFFECTIVE DATE.** This section is effective for gross revenues received after June
253.20 30, 2025.

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

253.22 Subd. 4. **Use tax; legend drugs.** (a) A person that receives legend drugs for resale or
253.23 use in Minnesota, other than from a wholesale drug distributor that is subject to tax under
253.24 subdivision 3, is subject to a tax equal to the price paid for the legend drugs multiplied by
253.25 ~~1.8~~ two percent. Liability for the tax is incurred when legend drugs are received or delivered
253.26 in Minnesota by the person.

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

254.1 **EFFECTIVE DATE.** This section is effective for gross revenues received after June
254.2 30, 2025.

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

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

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

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

254.9 (1) an individual enrolled in a Medicare plan;

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

254.11 (3) an individual enrolled in a health plan pursuant to the Federal Employees Health
254.12 Benefits Act of 1959, Public Law 86-382, as amended, to the extent the imposition of the
254.13 assessment under this section is preempted pursuant to United States Code, title 5, section
254.14 8909, subsection (f).

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

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

254.17 (f) "Medical assistance" means the medical assistance program established under chapter
254.18 256B.

- 254.19 (g) "Medical assistance enrollee" means an enrollee in medical assistance or
254.20 MinnesotaCare for whom the Department of Human Services directly pays the health plan
254.21 company a capitated payment.
- 254.22 (h) "MinnesotaCare" means the MinnesotaCare program established under chapter 256L.
- 254.23 (i) "Plan-to-plan enrollee" means an individual who receives coverage for health care
254.24 services through a health plan pursuant to a subcontract from another health plan.
- 254.25 Subd. 2. **MCO assessment.** (a) An annual assessment is imposed on health plan
254.26 companies for each calendar year beginning in calendar year 2026. The total annual
254.27 assessment amount is equal to the sum of the amounts assessed for medical assistance
254.28 enrollees under paragraph (b) and for nonmedical assistance enrollees under paragraph (c).
- 254.29 (b) The amount assessed for medical assistance enrollees is equal to the sum of the
254.30 following:
- 255.1 (1) for medical assistance enrollees 0 to 60,000, \$0 per enrollee;
- 255.2 (2) for medical assistance enrollees 60,001 to 100,000, \$340 per enrollee;
- 255.3 (3) for medical assistance enrollees 100,001 to 200,000, \$365 per enrollee; and
- 255.4 (4) for medical assistance enrollees 200,001 to 350,000, \$380 per enrollee.
- 255.5 (c) The amount assessed for nonmedical assistance enrollees is equal to the sum of the
255.6 following:
- 255.7 (1) for nonmedical assistance enrollees 0 to 60,000, \$0 per enrollee;
- 255.8 (2) for nonmedical assistance enrollees 60,001 to 100,000, 50 cents per enrollee;
- 255.9 (3) for nonmedical assistance enrollees 100,001 to 200,000, 75 cents per enrollee; and
- 255.10 (4) for nonmedical assistance enrollees 200,001 to 350,000, \$1 per enrollee.
- 255.11 (d) The commissioner must annually use the commissioner's authority as necessary to
255.12 modify the rate of assessment, provided under paragraph (e), such that the annual assessment
255.13 imposed under this subdivision does not exceed the lesser of:
- 255.14 (1) 2.8 percent of the health plan companies' aggregate gross revenue; and
- 255.15 (2) the cumulative costs attributable to:
- 255.16 (i) the program changes in section 295.525, subdivision 4, paragraph (b), clauses (1) to
255.17 (6); and
- 255.18 (ii) the appropriation under section 144E.54, subdivision 10.

- 255.19 (e) The commissioner may, after consultation with health plan companies likely to be
255.20 affected, modify the rate of assessment, as set forth in paragraphs (a) to (d), as necessary
255.21 to:
- 255.22 (1) comply with federal law, obtain or maintain a waiver under Code of Federal
255.23 Regulations, title 42, section 433.72, or to otherwise maximize under this section federal
255.24 financial participation for medical assistance; and
- 255.25 (2) comply with paragraph (d).
- 255.26 (f) Unpaid assessment amounts accrue interest at a rate of ten percent per annum,
255.27 beginning the day following the assessment payment's due date. A penalty, equal to the
255.28 total accrued interest charge, is imposed monthly on payments 60 days or more overdue
255.29 until the payment, penalty, and interest are paid in full.
- 256.1 Subd. 3. **Assessment computation; collection.** (a) The commissioner must annually
256.2 determine the following for each health plan company:
- 256.3 (1) total enrollment for the calendar year;
- 256.4 (2) total Medicare enrollment for the calendar year;
- 256.5 (3) total medical assistance enrollment for the calendar year;
- 256.6 (4) total plan-to-plan enrollment for the calendar year;
- 256.7 (5) total enrollment through the Federal Employees Health Benefits Act of 1959, Public
256.8 Law 86-382, as amended, for the calendar year; and
- 256.9 (6) total other enrollment for the calendar year that is not otherwise counted in clauses
256.10 (2) to (5).
- 256.11 (b) Health plan companies must provide any information requested by the commissioner
256.12 for the purpose of this subdivision, provided that the commissioner determines such
256.13 information is necessary to accurately determine the information in paragraph (a).
- 256.14 (c) The commissioner may correct errors in data provided to the commissioner by a
256.15 health plan company to the extent necessary to accurately determine the information in
256.16 paragraph (a).
- 256.17 (d) For purposes of calculating the information in paragraph (a) for a health plan company,
256.18 the commissioner must count any individual that was an enrollee of a health plan at any
256.19 point of the calendar year, regardless of the enrollee's duration as an enrollee of the health
256.20 plan.
- 256.21 (e) The commissioner must annually use the information in paragraph (a) to compute
256.22 the assessment for each health plan company.
- 256.23 (f) The commissioner must collect the annual assessment for each health plan company
256.24 in four equal installments, in the manner and on the schedule determined by the

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

256.27 (1) the effective date of this section;

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

256.29 (3) the annual assessment amount.

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

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

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

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

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

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

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

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

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

84.6 (a) The commissioner of human services must immediately begin all necessary claims
84.7 analysis to calculate the assessment and payments required under Minnesota Statutes, section
84.8 256.9657, subdivision 2b, and the hospital directed payment program described in Minnesota
84.9 Statutes, section 256B.1974.

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

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

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

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

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

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

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

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

258.24 (a) The commissioner of human services must immediately begin all necessary claims
258.25 analysis to calculate the assessment and payments required under Minnesota Statutes, section
258.26 256.9657, subdivision 2b, and the hospital directed payment program described in Minnesota
258.27 Statutes, section 256B.1974.

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

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

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

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

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

84.30 Sec. 21. REQUEST FOR FEDERAL WAIVER.

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

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

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

85.8 Up to \$500,000 of the nonfederal share of the costs to the Department of Human Services
85.9 for implementation of the requirements under the county-assisted rural medical assistance
85.10 (CARMA) program under Minnesota Statutes, section 256B.695, must be paid via an
85.11 intergovernmental funds transfer to the commissioner of human services by each county or
85.12 group of counties authorized under Minnesota Statutes, section 256B.692, seeking to
85.13 administer a CARMA program. The costs must be paid in a manner that is in compliance
85.14 with the requirements of Code of Federal Regulations, title 42, section 433.51. Within one
85.15 year of receiving payment under this section, the commissioner must provide a settle-up
85.16 process for any county or group of counties authorized under Minnesota Statutes, section
85.17 256B.692, administering a CARMA program and making payment under this section to
85.18 document and adjust payments owed to account for the commissioner's actual implementation
85.19 costs for Minnesota Statutes, section 256B.695.

85.20 Sec. 23. MEDICAL ASSISTANCE COVERAGE OF TRADITIONAL HEALTH
85.21 CARE PRACTICES.

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

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

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

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

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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;

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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.

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86.29 (2) dental providers that primarily serve low-income and socioeconomically complex
86.30 populations;

86.31 (3) dental providers that serve private-pay patients as well as medical assistance and
86.32 MinnesotaCare enrollees;

87.1 (4) rural critical access dental providers that do not have clinics in the seven-county
87.2 metropolitan area as defined in Minnesota Statutes, section 473.121, subdivision 2; and

87.3 (5) managed care plans.

87.4 Subd. 2. **Recommendations.** (a) The working group must provide recommendations to
87.5 the commissioner on:

87.6 (1) establishing and implementing a dental payment rate structure for medical assistance
87.7 and MinnesotaCare that:

87.8 (i) is based on the most recent cost data available;

87.9 (ii) promotes accountability while considering geographic differences in access to and
87.10 cost of dental services, critical access dental status, patient characteristics, transportation
87.11 needs, and medical and dental benefit coordination; and

87.12 (iii) can be updated regularly;

87.13 (2) performance benchmarks that focus on improving oral health for medical assistance
87.14 and MinnesotaCare enrollees, including consideration of Dental Quality Alliance and Oral
87.15 Health Impact Profile measures for broader assessment of a full range of services, and the
87.16 feasibility, cost, and value of providing the services;

87.17 (3) methods for measuring progress toward the performance benchmarks and holding
87.18 the dental administrator accountable for progress, including providing rewards for progress;

87.19 (4) establishing goals and processes to ensure coordination of care among medical
87.20 assistance and MinnesotaCare providers, including dental, medical, and other care providers,
87.21 particularly for patients with complex cases engaged in active treatment plans at the time
87.22 of transition to the dental administrator under Minnesota Statutes, section 256B.0371;

87.23 (5) developing and implementing an infrastructure and workforce development strategy
87.24 that invests in the medical assistance and MinnesotaCare dental system through grants and
87.25 loans at a level that enables continued development of dental capacity commensurate with
87.26 that obtained through the managed care delivery system and from philanthropic sources;
87.27 and

87.28 (6) developing and implementing a workforce development strategy to support the
87.29 pipeline of dental providers and oral health practitioners at all levels.

87.30 (b) The working group must provide the recommendations required under this subdivision
87.31 to the commissioner by

88.1 Subd. 3. **Reporting requirements.** (a) By, the commissioner, in consultation with
88.2 its contracted dental administrator, must develop an implementation plan and timeline to
88.3 effectuate the recommendations from the working group under this section.

88.4 (b) By, the commissioner must submit a report with the working group
88.5 recommendations, implementation plan, timeline, and any draft legislation required to
88.6 implement the implementation plan to the chairs and ranking minority members of the
88.7 legislative committees with jurisdiction over health and human services policy and finance.

259.15 Sec. 30. **FEDERAL APPROVAL; WAIVERS.**

259.16 (a) The commissioner must request, as the commissioner determines necessary, federal
259.17 approval for the MCO assessment on health plan companies established in this act to be
259.18 considered a permissible health-care-related tax under Code of Federal Regulations, title
259.19 42, section 433.68, eligible for federal financial participation.

259.20 (b) To obtain the federal approval under paragraph (a), the commissioner may apply for
259.21 a waiver of the federal broad-based requirement for health care-related taxes, uniform
259.22 requirement for health-care-related taxes, and any other provision of federal law necessary
259.23 to implement Minnesota Statutes, section 295.525.

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

259.25 Sec. 31. **BUDGET NEUTRALITY; RATE ADJUSTMENTS.**

259.26 (a) By October 1 of each year, the commissioner of human services must determine the
259.27 difference between the actual costs or forecasted costs to the medical assistance and
259.28 MinnesotaCare programs attributable to the program changes in Minnesota Statutes, section
259.29 295.525, subdivision 4, paragraph (b), clauses (1) to (6), and the revenue from the MCO
259.30 assessment imposed under Minnesota Statutes, section 295.525, subdivision 2, including
259.31 federal financial participation.

260.1 (b) For each fiscal year, the commissioner of human services must certify the difference
260.2 between the actual costs or forecasted costs to the medical assistance and MinnesotaCare
260.3 programs determined under paragraph (a), and report the difference in costs to the
260.4 commissioner of management and budget at least four weeks prior to a forecast under
260.5 Minnesota Statutes, section 16A.103.

260.6 (c) If for any fiscal year, the cumulative costs attributable to: (1) the program changes
260.7 in Minnesota Statutes, section 295.525, subdivision 4, paragraph (b), clauses (1) to (6), and
260.8 (2) the appropriation under section 144E.54, subdivision 10, exceed revenue from the MCO
260.9 assessment imposed under Minnesota Statutes, section 295.525, subdivision 2, as determined
260.10 under paragraph (a), the commissioner of human services must reduce the costs to the

88.8 Sec. 26. **REPEALER.**
88.9 (a) Laws 2023, chapter 70, article 16, section 22, is repealed.
88.10 (b) Minnesota Statutes 2024, section 256B.0625, subdivisions 18b, 18e, and 18h, are
88.11 repealed.
88.12 **EFFECTIVE DATE.** Paragraph (b) is effective July 1, 2026, for medical assistance
88.13 fee-for-service and January 1, 2027, for prepaid medical assistance.

260.11 medical assistance and MinnesotaCare programs attributable to the program changes in
260.12 Minnesota Statutes, section 295.525, subdivision 4, paragraph (b), clauses (1) to (6). The
260.13 commissioner's reduction under this paragraph must be on a uniform percentage basis across
260.14 the rate increases provided in Minnesota Statutes, section 295.525, subdivision 4, paragraph
260.15 (b), clauses (1) to (6).
260.16 Sec. 32. **TREND LIMIT; CALCULATION.**
260.17 (a) Beginning January 1, 2027, and ending June 30, 2029, the commissioner of human
260.18 services may limit the trend increase in rates paid to managed care plans and county-based
260.19 purchasing plans under Minnesota Statutes, sections 256B.69 and 256B.692, by an amount
260.20 equal to the value of a 0.35 percent reduction in trend in medical assistance. Managed care
260.21 rates must meet actuarial soundness and rate development requirements under Code of
260.22 Federal Regulations, title 42, part 438, subpart A.
260.23 (b) In the November 2025 forecast, the commissioner of human services, in consultation
260.24 with the commissioner of management and budget, must reduce the forecasted trend growth
260.25 in managed care for medical assistance expenditures in fiscal years 2027, 2028, and 2029.
260.26 The reduction must not be less than \$7,784,000 in fiscal year 2027, \$8,219,000 in fiscal
260.27 year 2028, and \$8,446,000 in fiscal year 2029.
260.28 Sec. 33. **PROGRAM FOR AMBULANCE SERVICE PROVIDER FUNDING.**
260.29 The commissioner of human services may implement a voluntary program to increase
260.30 funding to ambulance service providers licensed under Minnesota Statutes, chapter 144E,
260.31 for services delivered to enrollees of fee-for-service medical assistance and medical assistance
260.32 delivered by managed care and county-based purchasing plans. In developing the program,
260.33 the commissioner of human services must consider a range of approaches, including but
261.1 not limited to intergovernmental transfer and certified public expenditure programs, as
261.2 allowed under Code of Federal Regulations, title 42, section 433.51. The program must
261.3 supplement, and not supplant or replace, any existing programs operated by the commissioner
261.4 of human services to increase funding to ambulance service providers.

261.5 Sec. 34. **REPEALER.**

261.6 Minnesota Statutes 2024, section 256B.0625, subdivision 38, is repealed.

261.7 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval
261.8 of this section and the amendments in this act to Minnesota Statutes, sections 256B.76,
261.9 subdivision 6, and 256B.761, whichever is later. The commissioner of human services shall
261.10 notify the revisor of statutes when federal approval is obtained.