Senator ..... moves to amend S.F. No. 1402 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2024, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

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

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

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

(c) Effective for services provided statewide on or after January 1, 2026, medical assistance payment rates for ambulance services are increased by the amount of nonfederal and federal funds available for medical assistance pursuant to section 295.525, subdivision 4, paragraph (b). Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2026, must be increased to reflect this rate increase.

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

~~(d)~~ (e) Managed care plans and county-based purchasing plans must provide a fuel adjustment for ambulance services rates when fuel exceeds $3 per gallon. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph. This paragraph expires if federal approval is not received for this paragraph at any time.

Sec. 2. **[295.525] MCO ASSESSMENT ON HEALTH PLAN COMPANIES.**

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

(b) "Base year" means January 1, 2025, to December 31, 2025.

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

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

(1) an individual enrolled in a Medicare plan;

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

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

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

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

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

(h) "Medical assistance enrollee" means an enrollee in medical assistance for whom the department of human services directly pays the health plan company a capitated payment.

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

Subd. 2. **MCO assessment.** (a) An annual assessment is imposed on health plan companies for calendar years 2026 to 2029. The total annual assessment amount is equal to the sum of the amounts assessed for medical assistance enrollees under paragraph (b) and for nonmedical assistance enrollees under paragraph (c).

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

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

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

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

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

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

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

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

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

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

(d) The commissioner may, after consultation with health plan companies likely to be affected, modify the rate of assessment, as set forth in paragraphs (a) to (c), as necessary to comply with federal law, obtain or maintain a waiver under Code of Federal Regulations, title 42, section 433.72, or to otherwise maximize under this section federal financial participation for medical assistance.

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

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

(1) total cumulative enrollment for the base year;

(2) total Medicare cumulative enrollment for the base year;

(3) total medical assistance cumulative enrollment for the base year;

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

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

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

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

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

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

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

(f) The commissioner must collect the annual assessment for each health plan company in four equal installments, in the manner and on the schedule determined by the commissioner. The commissioner is prohibited from collecting any amount under this section until 20 days after the commissioner has notified the health plan company of:

(1) the effective date of this section;

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

(3) the annual assessment amount.

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

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

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

(b) All amounts collected by the commissioner under this section are annually appropriated to the commissioner to provide nonfederal funds for medical assistance for the increase in payment rates for ambulance services set forth in section 256B.0625, subdivision 17a, paragraph (c). The assessment funds must be used to supplement funds for medical assistance from the general fund.

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

Subd. 5. **Expiration.** This section expires June 30, 2030.

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

Sec. 3. **FEDERAL APPROVAL; WAIVERS.**

(a) The commissioner must request, as the commissioner determines necessary, federal approval for the MCO assessment on health plan companies established in this act to be

considered a permissible health care-related tax under Code of Federal Regulations, title 42, section 433.68, eligible for federal financial participation.

(b) To obtain the federal approval under paragraph (a), the commissioner may apply for a waiver of the federal broad-based requirement for health care-related taxes, uniform requirement for health care-related taxes, and any other provision of federal law necessary to implement Minnesota Statutes, section 295.525.

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

Amend the title accordingly