State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 1259

02/15/2017 Authored by Gruenhagen, Davids, Loonan and Pierson
The bill was read for the first time and referred to the Committee on Health and Human Services Reform

A bill for an act

relating to human services; requiring the commissioner of human services to establish and implement a premium subsidy program; establishing a state tax credit for premium payments for qualified individuals; repealing MinnesotaCare; appropriating money; amending Minnesota Statutes 2016, sections 256.98, subdivision 1; 256B.021, subdivision 4; 270A.03, subdivision 5; 270B.14, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 256; 290; repealing Minnesota Statutes 2016, sections 13.461, subdivision 26; 16A.724, subdivisions 3, 4; 62A.046, subdivision 5; 256L.01, subdivisions 1, 1a, 1b, 2, 3, 3a, 5, 6, 7; 256L.02, subdivisions 1, 2, 5, 6; 256L.03, subdivisions 1, 1a, 1b, 2, 3, 3a, 3b, 4, 4a, 5, 6; 256L.04, subdivisions 1, 1a, 1c, 2, 7, 7a, 7b, 10, 12, 13, 14; 256L.05, subdivisions 1, 1a, 2, 2a, 3, 3a, 4, 6; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3, 4; 256L.09, subdivisions 1, 2, 4, 5, 6, 7; 256L.10; 256L.11, subdivisions 1, 2, 2a, 3, 4, 7; 256L.12; 256L.121; 256L.15, subdivisions 1, 1a, 1b, 2; 256L.18.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

STATE SUBSIDY FOR QUALIFIED HEALTH PLAN COVERAGE; STATE TAX CREDIT

Section 1. **[256.0125] QUALIFIED HEALTH PLAN COVERAGE SUBSIDY PROGRAM.**

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

(b) "Affordable Care Act" has the meaning given in section 62K.03, subdivision 2.

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

(d) "MNsure" has the meaning given in section 62V.02, subdivision 8.

(e) "Qualified health plan" has the meaning given in section 62K.03, subdivision 11.

(f) "Qualified individual" means a Minnesota resident with:

(1) an income greater than 133 percent but not exceeding 200 percent of the federal poverty guidelines; or

(2) an income equal to or less than 133 percent of the federal poverty guidelines, if the person would have been eligible for MinnesotaCare under the eligibility criteria in effect on December 31, 2017.

(g) "Subsidy program" means the qualified health plan subsidy program established by this section.

Subd. 2. **Subsidy program.** The commissioner shall establish and implement a subsidy program to provide, effective January 1, 2018, premium subsidies to qualified individuals who purchase qualified health plans in the individual market. A qualified health plan offered under this section must meet the requirements for qualified health plans certified under chapter 62V and the requirements for qualified health plans specified in the Affordable Care Act.

Subd. 3. **Qualified individuals.** (a) Qualified individuals are eligible for state premium tax credits under section 290.0661 and premium subsidies under subdivision 4.

(b) Qualified individuals are not eligible to directly receive advanced premium tax credits and cost-sharing reductions through MNsure.

Subd. 4. **Subsidized premium.** The commissioner shall calculate a subsidized premium for each qualified individual. The subsidized premium shall be calculated using the sliding scale specified in section 256L.15, subdivision 2. The commissioner may modify this sliding scale to operate the subsidy program within the limits of available funding.

Subd. 5. **Payments to health carriers; individual financial obligation.** (a) The commissioner shall make payments to health carriers on behalf of qualified individuals for the months for which the individual has paid the subsidized premium calculated under subdivision 4 to the health carrier. The commissioner shall establish a maximum allowed premium that varies by the number of persons covered and geographic region, for purposes of calculating these payments. Payments to health carriers for a qualified individual shall equal the difference between the maximum allowed premium for that individual and the subsidized premium for that individual calculated under subdivision 4. In addition to paying the subsidized premium to the health carrier, a qualified individual is also responsible for paying to the health carrier any difference between the full premium charged by the health carrier and the maximum allowed premium.

(b) Health carriers seeking reimbursement from the commissioner must submit an invoice and supporting information to the commissioner, using a form developed by the commissioner, in order to be eligible for payment.

Sec. 2. **[256.0145] STATE INNOVATION WAIVER.**

The commissioner shall apply to the federal Centers for Medicare and Medicaid Services for a state innovation section 1332 waiver. The commissioner's waiver proposal must seek federal payments to the state equal to the advanced premium tax credits and cost-sharing reductions that qualified individuals receiving state premium subsidies under section 256.0125 would have received, had they not received state premium subsidies. The waiver proposal shall request receipt of federal payments beginning January 1, 2018.

Sec. 3. **[290.0661] STATE TAX CREDIT FOR PREMIUM PAYMENTS.**

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

(b) "Federal poverty guidelines" means the federal poverty guidelines published by the United States Department of Health and Human Services that apply to calculate the individual's premium support credit under section 36B of the Internal Revenue Code for the taxable year.

(c) "Qualified health plan" has the meaning given in section 256.0125, subdivision 1.

(d) "Qualified individual" has the meaning given in section 256.0125, subdivision 1.

Subd. 2. **Credit allowed.** (a) A qualified individual is allowed a credit against the tax imposed by this chapter equal to the amount determined under subdivision 3.

(b) For a part-year resident, the credit must be allocated based on the percentage calculated under section 290.06, subdivision 2c, paragraph (e).

Subd. 3. **Calculation of credit amount.** (a) The commissioner, in consultation with the commissioner of human services, shall provide qualified individuals with tax credits that reduce the cost of household premiums for qualified health plans by specified dollar amounts. The dollar amount of the tax credit must equal the base premium reduction amount, adjusted for household size. The commissioner shall establish separate base premium reduction amounts, based on a sliding scale, for:

(1) households with incomes not exceeding 150 percent of the federal poverty guidelines; and

(2) households with incomes greater than 150 percent but not exceeding 200 percent of the federal poverty guidelines.

(b) The commissioner, in developing the tax credit methodology and the base premium reduction amounts, shall ensure that aggregate tax credits provided under this section do not exceed $50,000,000 per taxable year.

Subd. 4. **Credit refundable; appropriation.** (a) If the credit allowed under this section exceeds the individual's liability under this chapter, the commissioner shall refund the excess to the taxpayer.

(b) An amount sufficient to pay the credits required by this section is annually appropriated from the general fund to the commissioner.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2017.

ARTICLE 2

REPEAL OF MINNESOTACARE

Section 1. Minnesota Statutes 2016, section 256.98, subdivision 1, is amended to read:

Subdivision 1. **Wrongfully obtaining assistance.** A person who commits any of the following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897, ~~the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program formerly codified in sections 256.72 to 256.871,~~ chapter 256B, 256D, 256J, 256K, or 256L, child care assistance programs, and emergency assistance programs under section 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses (1) to (5):

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of any material fact, or by impersonation or other fraudulent device, assistance or the continued receipt of assistance, to include child care assistance or vouchers produced according to sections 145.891 to 145.897 and ~~MinnesotaCare services according to sections~~ premium assistance under section 256.9365~~, 256.94, and 256L.01 to 256L.15,~~ to which the person is not entitled or assistance greater than that to which the person is entitled;

(2) knowingly aids or abets in buying or in any way disposing of the property of a recipient or applicant of assistance without the consent of the county agency; or

(3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments to which the individual is not entitled as a provider of subsidized child care, or by furnishing or concurring in a willfully false claim for child care assistance.

The continued receipt of assistance to which the person is not entitled or greater than that to which the person is entitled as a result of any of the acts, failure to act, or concealment described in this subdivision shall be deemed to be continuing offenses from the date that the first act or failure to act occurred.

Sec. 2. Minnesota Statutes 2016, section 256B.021, subdivision 4, is amended to read:

Subd. 4. **Projects.** The commissioner shall request permission and funding to further the following initiatives.

(a) Health care delivery demonstration projects. This project involves testing alternative payment and service delivery models in accordance with sections 256B.0755 and 256B.0756. These demonstrations will allow the Minnesota Department of Human Services to engage in alternative payment arrangements with provider organizations that provide services to a specified patient population for an agreed upon total cost of care or risk/gain sharing payment arrangement, but are not limited to these models of care delivery or payment. Quality of care and patient experience will be measured and incorporated into payment models alongside the cost of care. Demonstration sites should include Minnesota health care programs fee-for-services recipients and managed care enrollees and support a robust primary care model and improved care coordination for recipients.

(b) Promote personal responsibility and encourage and reward healthy outcomes. This project provides Medicaid funding to provide individual and group incentives to encourage healthy behavior, prevent the onset of chronic disease, and reward healthy outcomes. Focus areas may include diabetes prevention and management, tobacco cessation, reducing weight, lowering cholesterol, and lowering blood pressure.

(c) Encourage utilization of high quality, cost-effective care. This project creates incentives through Medicaid and MinnesotaCare enrollee cost-sharing and other means to encourage the utilization of high-quality, low-cost, high-value providers, as determined by the state's provider peer grouping initiative under section 62U.04.

(d) Adults without children. This proposal includes requesting federal authority to impose a limit on assets for adults without children in medical assistance, as defined in section 256B.055, subdivision 15, who have a household income equal to or less than 75 percent of the federal poverty limit~~, and to impose a 180-day durational residency requirement in~~

~~MinnesotaCare, consistent with section 256L.09, subdivision 4, for adults without children, regardless of income~~.

(e) Empower and encourage work, housing, and independence. This project provides services and supports for individuals who have an identified health or disabling condition but are not yet certified as disabled, in order to delay or prevent permanent disability, reduce the need for intensive health care and long-term care services and supports, and to help maintain or obtain employment or assist in return to work. Benefits may include:

(1) coordination with health care homes or health care coordinators;

(2) assessment for wellness, housing needs, employment, planning, and goal setting;

(3) training services;

(4) job placement services;

(5) career counseling;

(6) benefit counseling;

(7) worker supports and coaching;

(8) assessment of workplace accommodations;

(9) transitional housing services; and

(10) assistance in maintaining housing.

(f) Redesign home and community-based services. This project realigns existing funding, services, and supports for people with disabilities and older Minnesotans to ensure community integration and a more sustainable service system. This may involve changes that promote a range of services to flexibly respond to the following needs:

(1) provide people less expensive alternatives to medical assistance services;

(2) offer more flexible and updated community support services under the Medicaid state plan;

(3) provide an individual budget and increased opportunity for self-direction;

(4) strengthen family and caregiver support services;

(5) allow persons to pool resources or save funds beyond a fiscal year to cover unexpected needs or foster development of needed services;

(6) use of home and community-based waiver programs for people whose needs cannot be met with the expanded Medicaid state plan community support service options;

(7) target access to residential care for those with higher needs;

(8) develop capacity within the community for crisis intervention and prevention;

(9) redesign case management;

(10) offer life planning services for families to plan for the future of their child with a disability;

(11) enhance self-advocacy and life planning for people with disabilities;

(12) improve information and assistance to inform long-term care decisions; and

(13) increase quality assurance, performance measurement, and outcome-based reimbursement.

This project may include different levels of long-term supports that allow seniors to remain in their homes and communities, and expand care transitions from acute care to community care to prevent hospitalizations and nursing home placement. The levels of support for seniors may range from basic community services for those with lower needs, access to residential services if a person has higher needs, and targets access to nursing home care to those with rehabilitation or high medical needs. This may involve the establishment of medical need thresholds to accommodate the level of support needed; provision of a long-term care consultation to persons seeking residential services, regardless of payer source; adjustment of incentives to providers and care coordination organizations to achieve desired outcomes; and a required coordination with medical assistance basic care benefit and Medicare/Medigap benefit. This proposal will improve access to housing and improve capacity to maintain individuals in their existing home; adjust screening and assessment tools, as needed; improve transition and relocation efforts; seek federal financial participation for alternative care and essential community supports; and provide Medigap coverage for people having lower needs.

(g) Coordinate and streamline services for people with complex needs, including those with multiple diagnoses of physical, mental, and developmental conditions. This project will coordinate and streamline medical assistance benefits for people with complex needs and multiple diagnoses. It would include changes that:

(1) develop community-based service provider capacity to serve the needs of this group;

(2) build assessment and care coordination expertise specific to people with multiple diagnoses;

(3) adopt service delivery models that allow coordinated access to a range of services for people with complex needs;

(4) reduce administrative complexity;

(5) measure the improvements in the state's ability to respond to the needs of this population; and

(6) increase the cost-effectiveness for the state budget.

(h) Implement nursing home level of care criteria. This project involves obtaining any necessary federal approval in order to implement the changes to the level of care criteria in section 144.0724, subdivision 11, and implement further changes necessary to achieve reform of the home and community-based service system.

(i) Improve integration of Medicare and Medicaid. This project involves reducing fragmentation in the health care delivery system to improve care for people eligible for both Medicare and Medicaid, and to align fiscal incentives between primary, acute, and long-term care. The proposal may include:

(1) requesting an exception to the new Medicare methodology for payment adjustment for fully integrated special needs plans for dual eligible individuals;

(2) testing risk adjustment models that may be more favorable to capturing the needs of frail dually eligible individuals;

(3) requesting an exemption from the Medicare bidding process for fully integrated special needs plans for the dually eligible;

(4) modifying the Medicare bid process to recognize additional costs of health home services; and

(5) requesting permission for risk-sharing and gain-sharing.

(j) Intensive residential treatment services. This project would involve providing intensive residential treatment services for individuals who have serious mental illness and who have other complex needs. This proposal would allow such individuals to remain in these settings after mental health symptoms have stabilized, in order to maintain their mental health and avoid more costly or unnecessary hospital or other residential care due to their other complex conditions. The commissioner may pursue a specialized rate for projects created under this section.

(k) Seek federal Medicaid matching funds for Anoka Metro Regional Treatment Center (AMRTC). This project involves seeking Medicaid reimbursement for medical services

provided to patients to AMRTC, including requesting a waiver of United States Code, title 42, section 1396d, which prohibits Medicaid reimbursement for expenditures for services provided by hospitals with more than 16 beds that are primarily focused on the treatment of mental illness. This waiver would allow AMRTC to serve as a statewide resource to provide diagnostics and treatment for people with the most complex conditions.

(l) Waivers to allow Medicaid eligibility for children under age 21 receiving care in residential facilities. This proposal would seek Medicaid reimbursement for any Medicaid-covered service for children who are placed in residential settings that are determined to be "institutions for mental diseases," under United States Code, title 42, section 1396d.

Sec. 3. Minnesota Statutes 2016, section 270A.03, subdivision 5, is amended to read:

Subd. 5. **Debt.** (a) "Debt" means a legal obligation of a natural person to pay a fixed and certain amount of money, which equals or exceeds $25 and which is due and payable to a claimant agency. The term includes criminal fines imposed under section 609.10 or 609.125, fines imposed for petty misdemeanors as defined in section 609.02, subdivision 4a, and restitution. A debt may arise under a contractual or statutory obligation, a court order, or other legal obligation, but need not have been reduced to judgment.

A debt includes any legal obligation of a current recipient of assistance which is based on overpayment of an assistance grant where that payment is based on a client waiver or an administrative or judicial finding of an intentional program violation; or where the debt is owed to a program wherein the debtor is not a client at the time notification is provided to initiate recovery under this chapter and the debtor is not a current recipient of food support, transitional child care, or transitional medical assistance.

(b) A debt does not include any legal obligation to pay a claimant agency for medical care, including hospitalization if the income of the debtor at the time when the medical care was rendered does not exceed the following amount:

(1) for an unmarried debtor, an income of $8,800 or less;

(2) for a debtor with one dependent, an income of $11,270 or less;

(3) for a debtor with two dependents, an income of $13,330 or less;

(4) for a debtor with three dependents, an income of $15,120 or less;

(5) for a debtor with four dependents, an income of $15,950 or less; and

(6) for a debtor with five or more dependents, an income of $16,630 or less.

(c) The commissioner shall adjust the income amounts in paragraph (b) by the percentage determined pursuant to the provisions of section 1(f) of the Internal Revenue Code, except that in section 1(f)(3)(B) the word "1999" shall be substituted for the word "1992." For 2001, the commissioner shall then determine the percent change from the 12 months ending on August 31, 1999, to the 12 months ending on August 31, 2000, and in each subsequent year, from the 12 months ending on August 31, 1999, to the 12 months ending on August 31 of the year preceding the taxable year. The determination of the commissioner pursuant to this subdivision shall not be considered a "rule" and shall not be subject to the Administrative Procedure Act contained in chapter 14. The income amount as adjusted must be rounded to the nearest $10 amount. If the amount ends in $5, the amount is rounded up to the nearest $10 amount.

(d) Debt also includes an agreement to pay a MinnesotaCare premium, regardless of the dollar amount of the premium authorized under Minnesota Statutes 2016, section 256L.15, subdivision 1a.

Sec. 4. Minnesota Statutes 2016, section 270B.14, subdivision 1, is amended to read:

Subdivision 1. **Disclosure to commissioner of human services.** (a) On the request of the commissioner of human services, the commissioner shall disclose return information regarding taxes imposed by chapter 290, and claims for refunds under chapter 290A, to the extent provided in paragraph (b) and for the purposes set forth in paragraph (c).

(b) Data that may be disclosed are limited to data relating to the identity, whereabouts, employment, income, and property of a person owing or alleged to be owing an obligation of child support.

(c) The commissioner of human services may request data only for the purposes of carrying out the child support enforcement program and to assist in the location of parents who have, or appear to have, deserted their children. Data received may be used only as set forth in section 256.978.

(d) The commissioner shall provide the records and information necessary to administer the supplemental housing allowance to the commissioner of human services.

(e) At the request of the commissioner of human services, the commissioner of revenue shall electronically match the Social Security numbers and names of participants in the telephone assistance plan operated under sections 237.69 to 237.71, with those of property tax refund filers, and determine whether each participant's household income is within the eligibility standards for the telephone assistance plan.

(f) The commissioner may provide records and information collected under sections 295.50 to 295.59 to the commissioner of human services for purposes of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law 102-234. Upon the written agreement by the United States Department of Health and Human Services to maintain the confidentiality of the data, the commissioner may provide records and information collected under sections 295.50 to 295.59 to the Centers for Medicare and Medicaid Services section of the United States Department of Health and Human Services for purposes of meeting federal reporting requirements.

(g) The commissioner may provide records and information to the commissioner of human services as necessary to administer the early refund of refundable tax credits.

~~(h) The commissioner may disclose information to the commissioner of human services necessary to verify income for eligibility and premium payment under the MinnesotaCare program, under section 256L.05, subdivision 2.~~

~~(i)~~ (h) The commissioner may disclose information to the commissioner of human services necessary to verify whether applicants or recipients for the Minnesota family investment program, general assistance, food support, Minnesota supplemental aid program, and child care assistance have claimed refundable tax credits under chapter 290 and the property tax refund under chapter 290A, and the amounts of the credits.

~~(j)~~ (i) The commissioner may disclose information to the commissioner of human services necessary to verify income for purposes of calculating parental contribution amounts under section 252.27, subdivision 2a.

Sec. 5. **REVISOR'S INSTRUCTION.**

In Minnesota Statutes and Minnesota Rules, the revisor of statutes, in consultation with the Department of Human Services, shall strike references to Minnesota Statutes, chapter 256L, and to statutory sections within that chapter, and shall make all necessary grammatical and conforming changes.

Sec. 6. **REPEALER.**

Subdivision 1. **MinnesotaCare program.** Minnesota Statutes 2016, sections 256L.01, subdivisions 1, 1a, 1b, 2, 3, 3a, 5, 6, and 7; 256L.02, subdivisions 1, 2, 5, and 6; 256L.03, subdivisions 1, 1a, 1b, 2, 3, 3a, 3b, 4, 4a, 5, and 6; 256L.04, subdivisions 1, 1a, 1c, 2, 7, 7a, 7b, 10, 12, 13, and 14; 256L.05, subdivisions 1, 1a, 2, 2a, 3, 3a, 4, and 6; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3, and 4; 256L.09, subdivisions 1, 2, 4, 5, 6, and

7; 256L.10; 256L.11, subdivisions 1, 2, 2a, 3, 4, and 7; 256L.12; 256L.121; 256L.15, subdivisions 1, 1a, 1b, and 2; and 256L.18, are repealed.

Subd. 2. **Conforming repealers.** Minnesota Statutes 2016, sections 13.461, subdivision 26; 16A.724, subdivisions 3 and 4; and 62A.046, subdivision 5, are repealed.

Sec. 7. **EFFECTIVE DATE.**

Sections 1 to 6 are effective January 1, 2018, unless a different date is specified.

APPENDIX
Article locations in 17-2808

13.461 HUMAN SERVICES DATA CODED ELSEWHERE.

Subd. 26. **MinnesotaCare.** Data sharing with other government agencies that is needed to verify income for eligibility and premium payment is governed by section 256L.05.

16A.724 HEALTH CARE ACCESS FUND.

Subd. 3. **MinnesotaCare federal receipts.** All federal funding received by Minnesota for implementation and administration of MinnesotaCare as a basic health program, as authorized in section 1331 of the Affordable Care Act, Public Law 111-148, as amended by Public Law 111-152, is appropriated to the commissioner of human services to be used only for the MinnesotaCare program under chapter 256L. Federal funding that is received for implementing and administering MinnesotaCare as a basic health program shall be used only for that program to purchase health care coverage for enrollees and reduce enrollee premiums and cost-sharing or provide additional enrollee benefits.

Subd. 4. **MinnesotaCare funding.** The commissioner of human services may expend money appropriated from the health care access fund for MinnesotaCare in either year of the biennium.

62A.046 COORDINATION OF BENEFITS.

Subd. 5. **Payment recovery.** The commissioner of human services shall recover payments made by the MinnesotaCare program from the responsible insurer, for services provided by the MinnesotaCare program and covered by the policy or plan of health insurance.

256L.01 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of this chapter, the following terms shall have the meanings given them.

Subd. 1a. **Child.** "Child" means an individual under 21 years of age.

Subd. 1b. **Affordable Care Act.** "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance or regulations issued under, these acts.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 3. **Eligible providers.** "Eligible providers" means those health care providers who provide covered health services to medical assistance recipients under rules established by the commissioner for that program.

Subd. 3a. **Family.** (a) Except as provided in paragraphs (c) and (d), "family" has the meaning given for family and family size as defined in Code of Federal Regulations, title 26, section 1.36B-1.

(b) The term includes children who are temporarily absent from the household in settings such as schools, camps, or parenting time with noncustodial parents.

(c) For an individual who does not expect to file a federal tax return and does not expect to be claimed as a dependent for the applicable tax year, "family" has the meaning given in Code of Federal Regulations, title 42, section 435.603(f)(3).

(d) For a married couple, "family" has the meaning given in Code of Federal Regulations, title 42, section 435.603(f)(4).

Subd. 5. **Income.** "Income" has the meaning given for modified adjusted gross income, as defined in Code of Federal Regulations, title 26, section 1.36B-1, and means a household's current income, or if income fluctuates month to month, the income for the 12-month eligibility period.

Subd. 6. **MNsure.** "MNsure" means the state health benefit exchange as defined in section 62V.02.

Subd. 7. **Participating entity.** "Participating entity" means a health carrier as defined in section 62A.01, subdivision 2; a county-based purchasing plan established under section 256B.692; an accountable care organization or other entity operating a health care delivery systems demonstration project authorized under section 256B.0755; an entity operating a county integrated health care delivery network pilot project authorized under section 256B.0756; or a network of health care providers established to offer services under MinnesotaCare.

256L.02 PROGRAM ADMINISTRATION.

Subdivision 1. **Purpose.** The MinnesotaCare program is established to promote access to appropriate health care services to assure healthy children and adults.

Subd. 2. **Commissioner's duties.** (a) The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide covered health services for eligible persons. Payment for these services shall be made to all participating entities under contract with the commissioner. The commissioner shall adopt rules to administer the MinnesotaCare program. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the Department of Human Services.

(b) A toll-free telephone number and Web site must be used to provide information about medical programs and to promote access to the covered services.

Subd. 5. **Federal approval.** (a) The commissioner of human services shall seek federal approval to implement the MinnesotaCare program under this chapter as a basic health program. In any agreement with the Centers for Medicare and Medicaid Services to operate MinnesotaCare as a basic health program, the commissioner shall seek to include procedures to ensure that federal funding is predictable, stable, and sufficient to sustain ongoing operation of MinnesotaCare. These procedures must address issues related to the timing of federal payments, payment reconciliation, enrollee risk adjustment, and minimization of state financial risk. The commissioner shall consult with the commissioner of management and budget, when developing the proposal for establishing MinnesotaCare as a basic health program to be submitted to the Centers for Medicare and Medicaid Services.

(b) The commissioner of human services, in consultation with the commissioner of management and budget, shall work with the Centers for Medicare and Medicaid Services to establish a process for reconciliation and adjustment of federal payments that balances state and federal liability over time. The commissioner of human services shall request that the secretary of health and human services hold the state, and enrollees, harmless in the reconciliation process for the first three years, to allow the state to develop a statistically valid methodology for predicting enrollment trends and their net effect on federal payments.

Subd. 6. **Coordination with MNsure.** MinnesotaCare shall be considered a public health care program for purposes of chapter 62V.

256L.03 COVERED HEALTH SERVICES.

Subdivision 1. **Covered health services.** (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of special education services, home care nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, and nursing home or intermediate care facilities services.

(b) No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

(c) Covered health services shall be expanded as provided in this section.

Subd. 1a. **Children; MinnesotaCare health care reform waiver.** Children are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program according to chapter 256B, except that abortion services under MinnesotaCare shall be limited as provided under subdivision 1. Children are exempt from the provisions of subdivision 5, regarding co-payments. Children who are lawfully residing in the United States but who are not "qualified noncitizens" under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all services provided under the medical assistance program according to chapter 256B.

Subd. 1b. **Pregnant women; eligibility for full medical assistance services.** A pregnant woman enrolled in MinnesotaCare is eligible for coverage of all services provided under the medical assistance program according to chapter 256B retroactive to the date of conception. Co-payments totaling $30 or more, paid after the date of conception, shall be refunded.

Subd. 2. **Alcohol and drug dependency.** Beginning July 1, 1993, covered health services shall include individual outpatient treatment of alcohol or drug dependency by a qualified health professional or outpatient program.

Persons who may need chemical dependency services under the provisions of this chapter shall be assessed by a local agency as defined under section 254B.01, and under the assessment provisions of section 254A.03, subdivision 3. A local agency or managed care plan under contract

with the Department of Human Services must place a person in need of chemical dependency services as provided in Minnesota Rules, parts 9530.6600 to 9530.6655. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for consolidated chemical dependency treatment fund services provided under the provisions of chapter 254B shall receive chemical dependency treatment services under the provisions of chapter 254B only if:

(1) they have exhausted the chemical dependency benefits offered under this chapter; or

(2) an assessment indicates that they need a level of care not provided under the provisions of this chapter.

Recipients of covered health services under the children's health plan, as provided in Minnesota Statutes 1990, section 256.936, and as amended by Laws 1991, chapter 292, article 4, section 17, and recipients of covered health services enrolled in the children's health plan or the MinnesotaCare program after October 1, 1992, pursuant to Laws 1992, chapter 549, article 4, sections 5 and 17, are eligible to receive alcohol and drug dependency benefits under this subdivision.

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown.

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0505 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

Subd. 3a. **Interpreter services.** Covered services include sign and spoken language interpreter services that assist an enrollee in obtaining covered health care services.

Subd. 3b. **Chiropractic services.** MinnesotaCare covers the following chiropractic services: medically necessary exams, manual manipulation of the spine, and x-rays.

Subd. 4. **Coordination with medical assistance.** The commissioner shall coordinate the provision of hospital inpatient services under the MinnesotaCare program with enrollee eligibility under the medical assistance spenddown.

Subd. 4a. **Loss ratio.** Health coverage provided through the MinnesotaCare program must have a medical loss ratio of at least 85 percent, as defined using the loss ratio methodology described in section 1001 of the Affordable Care Act.

Subd. 5. **Cost-sharing.** (a) Except as otherwise provided in this subdivision, the MinnesotaCare benefit plan shall include the following cost-sharing requirements for all enrollees:

(1) $3 per prescription for adult enrollees;

(2) $25 for eyeglasses for adult enrollees;

(3) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(4) $6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and $3.50 effective January 1, 2011; and

(5) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next-higher five cent increment.

(b) Paragraph (a) does not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 447.51.

(c) Paragraph (a), clause (3), does not apply to mental health services.

(d) MinnesotaCare reimbursements to fee-for-service providers and payments to managed care plans or county-based purchasing plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause (4), effective January 1, 2011.

(e) The commissioner, through the contracting process under section 256L.12, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (5). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care

plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(f) The commissioner shall increase co-payments for covered services in a manner sufficient to reduce the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(g) The cost-sharing changes authorized under paragraph (f) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

Subd. 6. **Lien.** When the state agency provides, pays for, or becomes liable for covered health services, the agency shall have a lien for the cost of the covered health services upon any and all causes of action accruing to the enrollee, or to the enrollee's legal representatives, as a result of the occurrence that necessitated the payment for the covered health services. All liens under this section shall be subject to the provisions of section 256.015. For purposes of this subdivision, "state agency" includes participating entities, under contract with the commissioner according to section 256L.121.

256L.04 ELIGIBLE PERSONS.

Subdivision 1. **Families with children.** Families with children with family income above 133 percent of the federal poverty guidelines and equal to or less than 200 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18 shall apply unless otherwise specified. Children under age 19 with family income at or below 200 percent of the federal poverty guidelines and who are ineligible for medical assistance by sole reason of the application of federal household composition rules for medical assistance are eligible for MinnesotaCare.

Subd. 1a. **Social Security number required.** Individuals and families applying for MinnesotaCare coverage must provide a Social Security number if required by Code of Federal Regulations, title 45, section 155.310 (a)(3).

Subd. 1c. **General requirements.** To be eligible for MinnesotaCare, a person must meet the eligibility requirements of this section. A person eligible for MinnesotaCare shall not be considered a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered through MNsure under chapter 62V.

Subd. 2. **Third-party liability and other medical support.** Individuals and families may cooperate with the state agency to identify potentially liable third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited to, complying with the notice requirements in section 256B.056, subdivision 9, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third-party payments.

Subd. 7. **Single adults and households with no children.** The definition of eligible persons includes all individuals and families with no children who have incomes that are above 133 percent and equal to or less than 200 percent of the federal poverty guidelines for the applicable family size.

Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under this section may not enroll in the MinnesotaCare program.

Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income limits under this section annually each July 1 as described in section 256B.056, subdivision 1c.

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States and lawfully present noncitizens as defined in Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens are ineligible for MinnesotaCare. For purposes of this subdivision, an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) Notwithstanding subdivisions 1 and 7, eligible persons include families and individuals who are lawfully present and ineligible for medical assistance by reason of immigration status and who have incomes equal to or less than 200 percent of federal poverty guidelines.

Subd. 12. **Persons in detention.** An applicant or enrollee residing in a correctional or detention facility is not eligible for MinnesotaCare, unless the applicant or enrollee is awaiting disposition of charges.

Subd. 13. **Families with relative caretakers, foster parents, or legal guardians.** Beginning January 1, 1999, in families that include a relative caretaker as defined in the medical assistance program, foster parent, or legal guardian, the relative caretaker, foster parent, or legal guardian may apply as a family or may apply separately for the children. If the caretaker applies separately for the children, only the children's income is counted and the provisions of subdivision 1, paragraph (b), do not apply. If the relative caretaker, foster parent, or legal guardian applies with the children, their income is included in the gross family income for determining eligibility and premium amount.

Subd. 14. **Coordination with medical assistance.** (a) Individuals eligible for medical assistance under chapter 256B are not eligible for MinnesotaCare under this section.

(b) The commissioner shall coordinate eligibility and coverage to ensure that individuals transitioning between medical assistance and MinnesotaCare have seamless eligibility and access to health care services.

256L.05 APPLICATION PROCEDURES.

Subdivision 1. **Application assistance and information availability.** (a) Applicants may submit applications online, in person, by mail, or by phone in accordance with the Affordable Care Act, and by any other means by which medical assistance applications may be submitted. Applicants may submit applications through MNsure or through the MinnesotaCare program. Applications and application assistance must be made available at provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches, community health offices, Women, Infants and Children (WIC) program sites, Head Start program sites, public housing councils, crisis nurseries, child care centers, early childhood education and preschool program sites, legal aid offices, and libraries, and at any other locations at which medical assistance applications must be made available. These sites may accept applications and forward the forms to the commissioner or local county human services agencies that choose to participate as an enrollment site. Otherwise, applicants may apply directly to the commissioner or to participating local county human services agencies.

(b) Application assistance must be available for applicants choosing to file an online application through MNsure.

Subd. 1a. **Person authorized to apply on applicant's behalf.** Beginning January 1, 1999, a family member who is age 18 or over or who is an authorized representative, as defined in the medical assistance program, may apply on an applicant's behalf.

Subd. 2. **Commissioner's duties.** The commissioner or county agency shall use electronic verification through MNsure as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual may be required to submit additional verification to the extent permitted under the Affordable Care Act. In addition, the commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the Department of Revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the MinnesotaCare program.

Subd. 2a. **Eligibility and coverage.** For purposes of this chapter, an individual is eligible for MinnesotaCare following a determination by the commissioner that the individual meets the eligibility criteria for the applicable period of eligibility. For an individual required to pay a premium, coverage is only available in each month of the applicable period of eligibility for which a premium is paid.

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. The effective date of coverage for new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's modified adjusted gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible

person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

(d) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, subdivision 1, paragraph (c), is the first day of the month following the month in which eligibility is approved.

Subd. 3a. **Redetermination of eligibility.** (a) An enrollee's eligibility must be redetermined on an annual basis, in accordance with Code of Federal Regulations, title 42, section 435.916 (a). The 12-month eligibility period begins the month of application. Beginning July 1, 2017, the commissioner shall adjust the eligibility period for enrollees to implement renewals throughout the year according to guidance from the Centers for Medicare and Medicaid Services.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. Coverage begins as provided in section 256L.06.

Subd. 4. **Application processing.** The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than 45 days from the date that the application is received by the Department of Human Services as set forth in Code of Federal Regulations, title 42, section 435.912.

Subd. 6. **Referral of veterans.** The commissioner shall ensure that all applicants for MinnesotaCare who identify themselves as veterans are referred to a county veterans service officer for assistance in applying to the United States Department of Veterans Affairs for any veterans benefits for which they may be eligible.

256L.06 PREMIUM ADMINISTRATION.

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month following the month for which the premium was due. Persons disenrolled for nonpayment may not reenroll prior to the first day of the month following the payment of an amount equal to two months' premiums.

(e) The commissioner shall forgive the past-due premium for persons disenrolled under paragraph (d) prior to issuing a premium invoice for the fourth month following disenrollment.

256L.07 ELIGIBILITY FOR MINNESOTACARE.

Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month in which the commissioner sends advance notice according to Code of Federal Regulations, title 42, section 431.211, that indicates the income of a family or individual exceeds program income limits.

Subd. 2. **Must not have access to employer-subsidized minimum essential coverage.** (a) To be eligible, a family or individual must not have access to subsidized health coverage that is affordable and provides minimum value as defined in Code of Federal Regulations, title 26, section 1.36B-2.

(b) This subdivision does not apply to a family or individual who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit.

Subd. 3. **Other health coverage.** (a) To be eligible, a family or individual must not have minimum essential health coverage, as defined by section 5000A of the Internal Revenue Code.

(b) For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to have minimum essential health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

Subd. 4. **Families with children in need of chemical dependency treatment.** Premiums for families with children when a parent has been determined to be in need of chemical dependency treatment pursuant to an assessment conducted by the county under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, who are eligible for MinnesotaCare under section 256L.04, subdivision 1, may be paid by the county of residence of the person in need of treatment for one year from the date the family is determined to be eligible or if the family is currently enrolled in MinnesotaCare from the date the person is determined to be in need of chemical dependency treatment. Upon renewal, the family is responsible for any premiums owed under section 256L.15. If the family is not currently enrolled in MinnesotaCare, the local county human services agency shall determine whether the family appears to meet the eligibility requirements and shall assist the family in applying for the MinnesotaCare program.

256L.09 RESIDENCY.

Subdivision 1. **Findings and purpose.** The legislature finds that the enactment of a comprehensive health plan for uninsured Minnesotans creates a risk that persons needing medical care will migrate to the state for the primary purpose of obtaining medical care subsidized by the state. The risk of migration undermines the state's ability to provide to legitimate state residents a valuable and necessary health care program which is an important component of the state's comprehensive cost containment and health care system reform plan. Intent-based residency requirements, which are expressly authorized under decisions of the United States Supreme Court, are an unenforceable and ineffective method of denying benefits to those persons the Supreme Court has stated may legitimately be denied eligibility for state programs. If the state is unable to limit eligibility to legitimate permanent residents of the state, the state faces a significant risk that it will be forced to reduce the eligibility and benefits it would otherwise provide to Minnesotans. The legislature finds that a durational residence requirement is a legitimate, objective, enforceable standard for determining whether a person is a permanent resident of the state. The legislature also finds low-income persons who have not lived in the state for the required time period will have access to necessary health care services through the medical assistance program and public and private charity care programs.

Subd. 2. **Residency requirement.** To be eligible for health coverage under the MinnesotaCare program, individuals and families with children must meet the residency requirements as provided by Code of Federal Regulations, title 42, section 435.403.

Subd. 4. **Eligibility as Minnesota resident.** (a) For purposes of this section, a permanent Minnesota resident is a person who has demonstrated, through persuasive and objective evidence, that the person is domiciled in the state and intends to live in the state permanently.

(b) To be eligible as a permanent resident, an applicant must demonstrate the requisite intent to live in the state permanently by:

(1) showing that the applicant maintains a residence at a verified address, through the use of evidence of residence described in section 256D.02, subdivision 12a, paragraph (b), clause (2);

(2) demonstrating that the applicant has been continuously domiciled in the state for no less than 180 days immediately before the application; and

(3) signing an affidavit declaring that (A) the applicant currently resides in the state and intends to reside in the state permanently; and (B) the applicant did not come to the state for the primary purpose of obtaining medical coverage or treatment.

(c) A person who is temporarily absent from the state does not lose eligibility for MinnesotaCare. "Temporarily absent from the state" means the person is out of the state for a temporary purpose and intends to return when the purpose of the absence has been accomplished. A person is not temporarily absent from the state if another state has determined that the person is a resident for any purpose. If temporarily absent from the state, the person must follow the requirements of the health plan in which the person is enrolled to receive services.

Subd. 5. **Persons excluded as permanent residents.** An individual or family that moved to Minnesota primarily to obtain medical treatment or health coverage for a preexisting condition is not a permanent resident.

Subd. 6. **12-month preexisting exclusion.** If the 180-day requirement in subdivision 4, paragraph (b), clause (2), is determined by a court to be unconstitutional, the commissioner of human services shall impose a 12-month preexisting condition exclusion on coverage for persons who have been domiciled in the state for less than 180 days.

Subd. 7. **Effect of a court determination.** If any paragraph, sentence, clause, or phrase of this section is for any reason determined by a court to be unconstitutional, the decision shall not affect the validity of the remaining portions of the section. The legislature declares that it would have passed each paragraph, sentence, clause, and phrase in this section, irrespective of the fact that any one or more paragraphs, sentences, clauses, or phrases is declared unconstitutional.

256L.10 APPEALS.

If the commissioner suspends, reduces, or terminates eligibility for the MinnesotaCare program, or services provided under the MinnesotaCare program, the commissioner must provide notification according to the laws and rules governing the medical assistance program. A MinnesotaCare program applicant or enrollee aggrieved by a determination of the commissioner has the right to appeal the determination according to section 256.045.

256L.11 PROVIDER PAYMENT.

Subdivision 1. **Medical assistance rate to be used.** Payment to providers under this chapter shall be at the same rates and conditions established for medical assistance, except as provided in this section.

Subd. 2. **Payment of certain providers.** Services provided by federally qualified health centers, rural health clinics, and facilities of the Indian health service shall be paid for according to the same rates and conditions applicable to the same service provided by providers that are not federally qualified health centers, rural health clinics, or facilities of the Indian health service.

Subd. 2a. **Payment rates; services for families and children under the MinnesotaCare health care reform waiver.** Subdivision 2 shall not apply to services provided to families with children who are eligible according to section 256L.04, subdivision 1, paragraph (a).

Subd. 3. **Inpatient hospital services.** Inpatient hospital services provided under section 256L.03, subdivision 3, shall be at the medical assistance rate.

Subd. 4. **Definition of medical assistance rate for inpatient hospital services.** The "medical assistance rate," as used in this section to apply to rates for providing inpatient hospital services, means the rates established under sections 256.9685 to 256.9695 for providing inpatient hospital services to medical assistance recipients who receive Minnesota family investment program assistance.

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after July 1, 2016, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 32.5 percent above the payment rate that would otherwise be paid to the provider, except for a dental clinic or dental group described in section 256B.76, subdivision 4, paragraph (b), in which the commissioner shall increase the payment rate by 30 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

256L.12 MANAGED CARE.

Subdivision 1. **Selection of vendors.** In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall, where possible, contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for managed care plans and managed care-like entities as defined by the final regulation implementing section 1331 of the Affordable Care Act regarding basic health plans, which may include: prepaid capitation programs, competitive bidding programs, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided.

Subd. 2. **Geographic area.** The commissioner shall designate the geographic areas in which eligible individuals must receive services through managed care plans.

Subd. 3. **Limitation of choice.** Persons enrolled in the MinnesotaCare program who reside in the designated geographic areas must enroll in a managed care plan to receive their health care services. Enrollees must receive their health care services from health care providers who are part of the managed care plan provider network, unless authorized by the managed care plan, in cases of medical emergency, or when otherwise required by law or by contract.

If only one managed care option is available in a geographic area, the managed care plan may require that enrollees designate a primary care provider from which to receive their health care. Enrollees will be permitted to change their designated primary care provider upon request to the managed care plan. Requests to change primary care providers may be limited to once annually. If more than one managed care plan is offered in a geographic area, enrollees will be enrolled in a managed care plan for up to one year from the date of enrollment, but shall have the right to change to another managed care plan once within the first year of initial enrollment. Enrollees may also change to another managed care plan during an annual 30-day open enrollment period. Enrollees shall be notified of the opportunity to change to another managed care plan before the start of each annual open enrollment period.

Enrollees may change managed care plans or primary care providers at other than the above designated times for cause as determined through an appeal pursuant to section 256.045.

Subd. 4. **Exemptions to limitations on choice.** All contracts between the Department of Human Services and prepaid health plans to serve medical assistance and MinnesotaCare recipients must comply with the requirements of United States Code, title 42, section 1396a (a)(23)(B), notwithstanding any waivers authorized by the United States Department of Health and Human Services pursuant to United States Code, title 42, section 1315.

Subd. 5. **Eligibility for other state programs.** MinnesotaCare enrollees who become eligible for medical assistance will remain in the same managed care plan if the managed care plan has a contract for that population. Managed care plans must participate in the MinnesotaCare program under a contract with the Department of Human Services in service areas where they participate in the medical assistance program.

Subd. 6. **Co-payments and benefit limits.** Enrollees are responsible for all co-payments in section 256L.03, subdivision 5, and shall pay co-payments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit.

Subd. 7. **Managed care plan vendor requirements.** The following requirements apply to all counties or vendors who contract with the Department of Human Services to serve MinnesotaCare recipients. Managed care plan contractors:

(1) shall authorize and arrange for the provision of the full range of services listed in section 256L.03 in order to ensure appropriate health care is delivered to enrollees;

(2) shall accept the prospective, per capita payment or other contractually defined payment from the commissioner in return for the provision and coordination of covered health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees;

(4) shall provide for an enrollee grievance process as required by the commissioner and set forth in the contract with the department;

(5) shall retain all revenue from enrollee co-payments;

(6) shall accept all eligible MinnesotaCare enrollees, without regard to health status or previous utilization of health services;

(7) shall demonstrate capacity to accept financial risk according to requirements specified in the contract with the department. A health maintenance organization licensed under chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required to demonstrate financial risk capacity, beyond that which is required to comply with chapters 62C and 62D; and

(8) shall submit information as required by the commissioner, including data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services.

Subd. 8. **Chemical dependency assessments.** The managed care plan shall be responsible for assessing the need and placement for chemical dependency services according to criteria set forth in Minnesota Rules, parts 9530.6600 to 9530.6655.

Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions, when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

(c) For services rendered on or after January 1, 2011, the commissioner shall withhold an additional three percent of managed care plan or county-based purchasing plan payments under this section. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year. The return of the withhold under this paragraph is not subject to the requirements of paragraph (b).

(d) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reductions shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous measurement year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous calendar year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement

year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospitals admission rate compared to the hospital admission rate for calendar year 2011 as determined by the commissioner. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (f).

(f) Effective for services provided on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospital admissions rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(g) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

Subd. 9a. **Rate setting; ratable reduction.** For services rendered on or after October 1, 2003, the total payment made to managed care plans under the MinnesotaCare program is reduced 1.0 percent. This provision excludes payments for mental health services added as covered benefits after December 31, 2007.

Subd. 9b. **Rate setting; ratable reduction.** In addition to the reduction in subdivision 9a, the total payment made to managed care plans under the MinnesotaCare program shall be reduced for services provided on or after January 1, 2006, to reflect a 6.0 percent reduction in reimbursement for inpatient hospital services.

Subd. 10. **Childhood immunization.** Each managed care plan contracting with the Department of Human Services under this section shall collaborate with the local public health agencies to ensure childhood immunization to all enrolled families with children. As part of this collaboration the plan must provide the families with a recommended immunization schedule.

Subd. 11. **Coverage at Indian health service facilities.** For American Indian enrollees of MinnesotaCare, MinnesotaCare shall cover health care services provided at Indian health service facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Act, Public Law 93-638, if those services would otherwise be covered under section 256L.03. Payments for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or organization, be made at the rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34, for those MinnesotaCare enrollees eligible for coverage at medical assistance rates. For purposes of this

subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in Code of Federal Regulations, title 42, section 36.12.

256L.121 SERVICE DELIVERY.

Subdivision 1. **Competitive process.** The commissioner of human services shall establish a competitive process for entering into contracts with participating entities for the offering of standard health plans through MinnesotaCare. Coverage through standard health plans must be available to enrollees beginning January 1, 2015. Each standard health plan must cover the health services listed in and meet the requirements of section 256L.03. The competitive process must meet the requirements of section 1331 of the Affordable Care Act and be designed to ensure enrollee access to high-quality health care coverage options. The commissioner, to the extent feasible, shall seek to ensure that enrollees have a choice of coverage from more than one participating entity within a geographic area. In counties that were part of a county-based purchasing plan on January 1, 2013, the commissioner shall use the medical assistance competitive procurement process under section 256B.69, under which selection of entities is based on criteria related to provider network access, coordination of health care with other local services, alignment with local public health goals, and other factors.

Subd. 2. **Other requirements for participating entities.** The commissioner shall require participating entities, as a condition of contract, to document to the commissioner:

(1) the provision of culturally and linguistically appropriate services, including marketing materials, to MinnesotaCare enrollees; and

(2) the inclusion in provider networks of providers designated as essential community providers under section 62Q.19.

Subd. 3. **Coordination with state-administered health programs.** The commissioner shall coordinate the administration of the MinnesotaCare program with medical assistance to maximize efficiency and improve the continuity of care. This includes, but is not limited to:

(1) establishing geographic areas for MinnesotaCare that are consistent with the geographic areas of the medical assistance program, within which participating entities may offer health plans;

(2) requiring, as a condition of participation in MinnesotaCare, participating entities to also participate in the medical assistance program;

(3) complying with sections 256B.69, subdivision 3a; 256B.692, subdivision 1; and 256B.694, when contracting with MinnesotaCare participating entities;

(4) providing MinnesotaCare enrollees, to the extent possible, with the option to remain in the same health plan and provider network, if they later become eligible for medical assistance or coverage through MNsure and if, in the case of becoming eligible for medical assistance, the enrollee's MinnesotaCare health plan is also a medical assistance health plan in the enrollee's county of residence; and

(5) establishing requirements and criteria for selection that ensure that covered health care services will be coordinated with local public health services, social services, long-term care services, mental health services, and other local services affecting enrollees' health, access, and quality of care.

256L.15 PREMIUMS.

Subdivision 1. **Premium determination for MinnesotaCare.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption applies for 12 months.

(c) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their families shall have their premiums waived by the commissioner in accordance with section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. An individual must indicate status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums. The commissioner shall accept attestation of an individual's status as an American Indian as verification until the United States Department of Health and Human Services approves an electronic data source for this purpose.

(d) For premiums effective August 1, 2015, and after, the commissioner, after consulting with the chairs and ranking minority members of the legislative committees with jurisdiction over

human services, shall increase premiums under subdivision 2 for recipients based on June 2015 program enrollment. Premium increases shall be sufficient to increase projected revenue to the fund described in section 16A.724 by at least $27,800,000 for the biennium ending June 30, 2017. The commissioner shall publish the revised premium scale on the Department of Human Services Web site and in the State Register no later than June 15, 2015. The revised premium scale applies to all premiums on or after August 1, 2015, in place of the scale under subdivision 2.

(e) By July 1, 2015, the commissioner shall provide the chairs and ranking minority members of the legislative committees with jurisdiction over human services the revised premium scale effective August 1, 2015, and statutory language to codify the revised premium schedule.

(f) Premium changes authorized under paragraph (d) must only apply to enrollees not otherwise excluded from paying premiums under state or federal law. Premium changes authorized under paragraph (d) must satisfy the requirements for premiums for the Basic Health Program under title 42 of Code of Federal Regulations, section 600.505.

Subd. 1a. **Payment options.** The commissioner may offer the following payment options to an enrollee:

(1) payment by check;

(2) payment by credit card;

(3) payment by recurring automatic checking withdrawal;

(4) payment by onetime electronic transfer of funds;

(5) payment by wage withholding with the consent of the employer and the employee; or

(6) payment by using state tax refund payments.

At application or reapplication, a MinnesotaCare applicant or enrollee may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to collect funds from the applicant's or enrollee's refund for the purposes of meeting all or part of the applicant's or enrollee's MinnesotaCare premium obligation. The applicant or enrollee may authorize the commissioner to apply for the state working family tax credit on behalf of the applicant or enrollee. The setoff due under this subdivision shall not be subject to the $10 fee under section 270A.07, subdivision 1.

Subd. 1b. **Payments nonrefundable.** Only MinnesotaCare premiums paid for future months of coverage for which a health plan capitation fee has not been paid may be refunded.

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).

(c) Paragraph (b) does not apply to:

(1) children 20 years of age or younger; and

(2) individuals with household incomes below 35 percent of the federal poverty guidelines.

(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
35%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$14
120%	130%	$15
130%	140%	$16
140%	150%	$25
150%	160%	$29
160%	170%	$33
170%	180%	$38

180%	190%	$43
190%		$50

256L.18 PENALTIES.

Whoever obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, or by the intentional withholding or concealment of a material fact, or by impersonation, or other fraudulent device:

(1) benefits under the MinnesotaCare program to which the person is not entitled; or

(2) benefits under the MinnesotaCare program greater than that to which the person is reasonably entitled;

shall be considered to have violated section 256.98, and shall be subject to both the criminal and civil penalties provided under that section.