A bill for an act

relating to health care; establishing a statewide health improvement program; establishing health care homes and reporting requirements; establishing a care coordination payment; increasing reimbursements to primary care physicians in certain areas; requiring a workforce shortage study; establishing requirements for interoperable health records; establishing electronic prescription drug program; establishing a value-based benefit set and design for health benefits; providing for health care payment restructuring; requiring uniform standards; establishing an affordability standard; requiring development of employee subsidies for health coverage; requiring a health care spending baseline be developed; establishing a health care reform review council; establishing Section 125 Plan; providing for fees; requiring reports; authorizing rulemaking; appropriating money; amending Minnesota Statutes 2006, sections 256.01, by adding a subdivision; 256B.057, subdivision 8; 256L.05, by adding a subdivision; 256L.06, subdivision 3; 256L.07, subdivision 3; Minnesota Statutes 2007 Supplement, sections 62J.495, by adding a subdivision; 256.962, subdivisions 5, 6; 256L.04, subdivisions 1, 7; 256L.05, subdivision 3a; 256L.07, subdivision 1; 256L.15, subdivision 2; Laws 2007, chapter 147, article 5, section 19; proposing coding for new law in Minnesota Statutes, chapters 62J; 124D; 145; 256B; proposing coding for new law as Minnesota Statutes, chapter 62U; repealing Minnesota Statutes 2006, section 256L.15, subdivision 3.

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

ARTICLE 1
PUBLIC HEALTH

Section 1. **[145.986] STATEWIDE HEALTH IMPROVEMENT PROGRAM.**

Subdivision 1. **Goals.** It is the goal of the state to substantially reduce the percentage of Minnesotans who are obese or overweight, and to reduce the use of tobacco.

Subd. 2. **Grants to local communities.** (a) Beginning July 1, 2009, the commissioner of health shall award grants to community health boards established pursuant to section 145A.09, and tribal governments to convene, coordinate, and

implement evidence-based strategies targeted at reducing the percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco.

(b) Grantee activities shall:

(1) be based on scientific evidence;

(2) be based on community input;

(3) address behavior change at the individual, community, and systems levels;

(4) occur in community, school, worksite, and health care settings; and

(5) be focused on policy, systems, and environmental changes that support healthy behaviors.

(c) To receive a grant under this section, community health boards and tribal governments must submit proposals to the commissioner. A local match of ten percent of the total funding allocation is required. This local match may include funds donated by community partners.

(d) In order to receive a grant, community health boards and tribal governments must submit a health improvement plan to the commissioner of health for approval. The commissioner may require the plan to identify a community leadership team, community partners, and a community action plan that includes an assessment of area strengths and needs, proposed action strategies, technical assistance needs, and a staffing plan.

(e) The grant recipient must implement the health improvement plan, evaluate the effectiveness of the interventions, and modify or discontinue interventions found to be ineffective.

(f) Grant recipients shall receive the standard base amount and a standard per capita amount to be established by the commissioner.

(g) By January 15, 2011, the commissioner of health shall recommend whether any funding should be distributed to community health boards and tribal governments based on health disparities demonstrated in the populations served.

(h) Grant recipients shall report their activities and their progress towards the outcomes established under subdivision 3 to the commissioner in a format and at a time specified by the commissioner.

(i) All grant recipients shall be held accountable for making progress toward the measurable outcomes established in subdivision 3. The commissioner shall require a corrective action plan and may reduce the funding level of grant recipients that do not make adequate progress toward the measurable outcomes.

Subd. 3. **Outcomes.** (a) The commissioner shall set measurable outcomes to meet the goals specified in subdivision 1, and annually review the progress of grant recipients in meeting the outcomes.

(b) The commissioner shall measure current public health status, using existing measures and data collection systems when available, to determine baseline data against which progress shall be monitored.

Subd. 4. **Technical assistance and oversight.** The commissioner shall provide content expertise, technical expertise, and training to grant recipients and advice on evidence-based strategies, including those based on populations and types of communities served. The commissioner shall ensure that the statewide health improvement program meets the outcomes established under subdivision 3 by conducting a comprehensive statewide evaluation and assisting grant recipients to modify or discontinue interventions found to be ineffective.

Subd. 5. **Evaluation.** Using the outcome measures established in subdivision 3, the commissioner shall conduct a biennial evaluation of the statewide health improvement program funded under this section. Grant recipients shall cooperate with the commissioner in the evaluation and provide the commissioner with the information necessary to conduct the evaluation.

Subd. 6. **Report.** The commissioner shall submit a biennial report to the legislature on the statewide health improvement program funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. In addition, the commissioner shall provide recommendations on future areas of focus for health improvement. These reports are due by January 15 of every other year, beginning in 2010. In the report due on January 15, 2010, the commissioner shall include recommendations on a sustainable funding source for the statewide health improvement program other than the health care access fund.

Subd. 7. **Supplantation of existing funds.** Community health boards and tribal governments must use funds received under this section to develop new programs, expand current programs that work to reduce the percentage of Minnesotans who are obese or overweight, or who use tobacco, or replace discontinued state or federal funds previously used to reduce the percentage of Minnesotans who are obese or overweight, or who use tobacco. Funds must not be used to supplant current state or local funding to community health boards or tribal governments used to reduce the percentage of Minnesotans who are obese or overweight or to reduce tobacco use.

ARTICLE 2
HEALTH CARE HOMES

Section 1. **[256B.0751] HEALTH CARE HOMES.**

Subdivision 1. **Definitions.** (a) For purposes of sections 256B.0751 to 256B.0753, the following definitions apply.

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

(c) "Commissioners" means the commissioner of humans services and the commissioner of health, acting jointly.

(d) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

(e) "Personal clinician" means a physician licensed under chapter 147, a physician assistant registered and practicing under chapter 147A, an advanced practice nurse licensed and registered to practice under chapter 148, and other health care providers as determined by the commissioner of health.

(f) "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Subd. 2. **Development and implementation of standards.** (a) By July 1, 2009, the commissioners of health and human services shall develop and implement standards of certification for health care homes for state health care programs. In developing these standards, the commissioners shall consider existing standards developed by national independent accrediting and medical home organizations. The standards developed by the commissioners must meet the following criteria:

(1) emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians, as well as appropriate specialists if they provide care according to these standards;

(2) focus on delivering high-quality, efficient, and effective health care services, enhancing the experience of patients and their families, and appropriately engaging patients and their families in the decision-making process;

(3) encourage patient-centered care, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate in decision making, care plan development, and include patient representation on practice level quality improvement teams;

(4) provide patients with a consistent, ongoing contact with a personal clinician to ensure continuous and appropriate care for the patient's condition;

(5) ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including the provision of an initial health assessment in order to identify all of the patient's complex or chronic health conditions;

(6) enable and encourage utilization of a range of qualified health care professionals to provide care, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;

(7) focus initially on patients who have or are at risk of developing chronic health conditions;

(8) provide care that is appropriate to the patient's race, ethnicity, and language;

(9) incorporate measures of quality and cost of care;

(10) ensure the use of health information technology and systematic follow-up through the use of patient registries; and

(11) encourage the use of evidence-based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

(b) In developing these standards, the commissioners shall consult with national and local organizations working on health care home models, health care providers, relevant state agencies, health plans, and hospitals. The commissioners may satisfy this requirement by continuing the provider directed care coordination advisory committee.

(c) For the purposes of developing and implementing these standards, the commissioners are exempt from the provisions of chapter 14, including the specific provisions in section 14.386.

Subd. 3. **Requirements for clinicians certified as health care homes.** (a) A personal clinician or a primary care clinic may be certified as a health care home. If a primary care clinic is certified, all of the primary care clinics' clinicians must meet the criteria of a health care home. In order to be certified as a health care home, a clinician or clinic must meet the standards set by the commissioners in accordance with this section. Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually.

(b) Clinicians or clinics certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

(c) Health care homes must participate in the health care home learning collaborative established under subdivision 5.

Subd. 4. **Alternative models.** Nothing in this section shall preclude the continued development of existing medical or health care home projects currently operating or under development by the commissioner of human services or preclude the commissioner from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs under section 256B.69, subdivisions 23

and 28, are enrolled in managed care long-term care programs under section 256B.69, subdivision 6, paragraph (b), are dually eligible for Medicare and medical assistance, are in the waiting period for Medicare, or who have other primary coverage.

Subd. 5. **Health care home collaborative.** By July 1, 2009, the commissioners shall establish a health care home collaborative to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

Subd. 6. **Evaluation and continued development.** (a) For continued certification under this section, health care homes must meet process, outcome, and quality standards as developed and specified by the commissioners. The commissioners shall collect data from health care homes necessary for monitoring compliance with certification standards and for evaluating the impact of health care homes on health care quality, cost, and outcomes.

(b) The commissioners may contract with a private entity to perform an evaluation of the effectiveness of health care homes. Data collected under this subdivision is classified as nonpublic data under chapter 13.

Subd. 7. **Outreach.** Upon implementation of the certification process and standards under subdivision 1, the commissioner shall encourage state health care program enrollees who have a complex or chronic condition to select a primary care clinic with clinicians who have been certified as health care homes.

Sec. 2. **[256B.0752] CARE COORDINATION FEE.**

Subdivision 1. **Development.** The commissioner of human services shall develop a payment system that provides per-person care coordination payments to health care providers for providing care coordination services and directly managing onsite or employing care coordinators. In order to be eligible for a care coordination payment, a health care provider must be certified as a health care home by the commissioners of human services and health based on the certification standards for health care homes established under section 256B.0751. The care coordination payment system must vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination and those who face racial, ethnic, or language barriers. The commissioner may determine a schedule for phasing-in care coordination fees such that the fees will be applied first to individuals who have, or are at risk of developing, complex or chronic health conditions and coordinate with the implementation of the provider-directed care coordination payments under section 256B.0625, subdivision 51. Development of the payment system must be completed by January 1, 2010.

Subd. 2. **Payment of care coordination fee.** By July 1, 2010, the commissioner of human services shall pay each certified health care home a per-person care coordination fee for providing care coordination services for each state health care program enrollee served under the fee-for-service system. The care coordination fee must be determined by the commissioner in contracts with certified health care homes. Payment of the care coordination fee is contingent on the health care home meeting the certification standards for health care homes described in section 256B.0751. The care coordination fee is in addition to reimbursement received by a health care home under the medical assistance fee-for-service payment system for health care services.

Subd. 3. **Managed care and county-based purchasing.** By July 1, 2010, the commissioner of human services shall require managed care and county-based purchasing plans serving state health care program enrollees under sections 256B.69 and 256B.692, and chapters 256D and 256L to implement a care coordination payment system for state health care program enrollees who are provided care coordination services in health care homes certified under section 256B.0751. The payment system shall be designed in accordance with section 62U.05.

Subd. 4. **Cost neutrality.** If initial savings from implementation of health care homes are not sufficient to allow implementation of the care coordination fee in a cost-neutral manner, the commissioner may make recommendations to the legislature on reallocating costs within the health care system.

EFFECTIVE DATE. This section is effective July 1, 2010, or upon federal approval, whichever is later.

Sec. 3. **[256B.0753] HEALTH CARE HOME REPORTING REQUIREMENTS.**

Subdivision 1. **Standards and criteria review.** Prior to implementation, the commissioners shall report the certification standards and evaluation criteria established in sections 256B.0751 and 256B.0752 to the Legislative Commission on Health Care Access. These standards are not subject to chapter 14, and the specific provisions in section 14.386 do not apply.

Subd. 2. **Annual reports on implementation and administration.** The commissioners shall report annually to the legislature on the implementation and administration of the health care home model for state health care program enrollees in the fee-for-service, managed care, and county-based purchasing sectors, beginning January 15, 2011, and each January 15 thereafter. The annual report must include the cost benefit analysis of the implementation of the health care home model for the state public health care programs.

Subd. 3. **Evaluation reports.** The commissioners shall provide to the legislature comprehensive evaluations of the health care home model three years and five years after implementation. The report must include:

(1) the number of state health care program enrollees in health care homes, the number and characteristics of enrollees with complex or chronic conditions, identified by income, race, ethnicity, and language;

(2) the number and geographic distribution of health care home providers;

(3) the performance and quality of care of health care homes;

(4) measures of preventive care;

(5) health care home payment arrangements, and costs related to implementation and payment of care coordination fees; and

(6) the estimated impact of health care homes on health disparities.

Sec. 4. **[256B.766] PRIMARY CARE PHYSICIAN REIMBURSEMENT RATE INCREASE.**

(a) Effective for physician services rendered on or after January 1, 2009, the commissioner shall increase reimbursements to primary care physicians deemed by the commissioner to meet the requirements in paragraph (b). Reimbursement may be increased by not more than 50 percent above the reimbursement rate that would otherwise be paid to the primary care provider. Payments to health plan companies shall be adjusted to reflect increased reimbursement to primary care physicians as approved by the commissioner.

(b) The commissioner, in collaboration with the Office of Rural Health, shall determine areas of the state in need of primary care physicians. By September 1 of each year, beginning September 1, 2008, the commissioner shall accept applications from primary care physicians who agree to practice in a designated underserved area for a period of no less than five years. The commissioner shall determine participant eligibility based on their suitability for practice serving a designated geographic area.

(c) The commissioner may reconsider the designated areas, as necessary. A primary care physician who agrees to practice in an area designated as underserved shall receive the increased reimbursement rates for at least a period of five years, unless the physician discontinues practicing in the designated area during the five-year period.

(d) A health care clinic or medical group may submit applications under this section for primary care physicians who will be hired to fill vacancies, prior to filling the vacant position.

Sec. 5. **WORKFORCE SHORTAGE STUDY.**

To address health care workforce shortages, the commissioner of health, in consultation with the health licensing boards and professional associations, shall study changes necessary in health professional licensure and regulation to ensure full utilization of advanced practice registered nurses, physician assistants, and other licensed health care professionals in the health care home and primary delivery system. The commissioner shall make recommendations to the legislature by January 15, 2009.

ARTICLE 3
INCREASING ACCESS; CONTINUITY OF CARE

Section 1. **[124D.1115] FREE AND REDUCED SCHOOL LUNCH PROGRAM DATA SHARING.**

(a) Each school participating in the federal school lunch program shall electronically send to the Department of Education the eligibility information on each child who is eligible for the free and reduced lunch program, unless the child's parent or legal guardian after being notified of the potential disclosure of this information for the limited purpose stated in paragraph (b), elects not to have the information disclosed.

(b) Pursuant to United States Code, title 42, section 1758(b)(6)(A), the Department of Education shall enter into an agreement with the Department of Human Services to share the eligibility information provided by each school in paragraph (a) for the limited purpose of identifying children who may be eligible for medical assistance or MinnesotaCare. The Department of Human Services must ensure that this information remains confidential and shall only be used for this purpose. Any unauthorized disclosure shall be subject to a penalty.

Sec. 2. Minnesota Statutes 2006, section 256.01, is amended by adding a subdivision to read:

Subd. 27. **Automation and coordination for state health care programs.** (a) For purposes of this subdivision, "state health care program" means the medical assistance, MinnesotaCare, or general assistance medical care programs.

(b) By July 1, 2009, the commissioner shall improve coordination between state health care programs and social service programs including, but not limited to WIC, free and reduced school lunch programs, and food stamps, and shall develop and use automated systems to identify persons served by social service programs who may be eligible for, but are not enrolled in, a state health care program. By January 15, 2009, the commissioner shall, as necessary, identify and recommend to the legislature statutory changes to state

health care and social service programs necessary to improve coordination and automation of outreach and enrollment efforts.

(c) By January 15, 2009, the commissioner shall establish and implement an automated process to send out state health care program renewal forms in the most common foreign languages, to those state health care program enrollees who request renewal forms in those foreign languages. The commissioner, as part of the initial enrollment process, shall inform applicants of the availability of this option.

(d) Beginning July 1, 2008, the commissioner, county social service agencies, and health care providers shall update state health care program enrollee addresses and related contact information, at the time of each enrollee contact.

EFFECTIVE DATE. This section is effective July 1, 2008.

Sec. 3. Minnesota Statutes 2007 Supplement, section 256.962, subdivision 5, is amended to read:

Subd. 5. **Incentive program.** Beginning January 1, 2008, the commissioner shall establish an incentive program for organizations that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in MinnesotaCare, medical assistance, or general assistance medical care, the commissioner, within the available appropriation, shall pay the organization a ~~$20~~ $25 application assistance bonus. The organization may provide an applicant a gift certificate or other incentive upon enrollment.

Sec. 4. Minnesota Statutes 2007 Supplement, section 256.962, subdivision 6, is amended to read:

Subd. 6. **School districts.** (a) At the beginning of each school year, a school district shall provide information to each student on the availability of health care coverage through the Minnesota health care programs.

(b) For each child who is determined to be eligible for ~~a~~ the free ~~or~~ and reduced ~~priced~~ school lunch program, the district shall provide the child's family with ~~an application for the Minnesota health care programs and~~ information on how to obtain an application for the Minnesota health care programs and application assistance.

(c) A district shall also ensure that applications and information on application assistance are available at early childhood education sites and public schools located within the district's jurisdiction.

(d) Each district shall designate an enrollment specialist to provide application assistance and follow-up services with families ~~who are eligible for the reduced or free~~

~~lunch program or~~ who have indicated an interest in receiving information or an application for the Minnesota health care program. A district is eligible for the application assistance bonus described in subdivision 5.

(e) Each school district shall provide on their Web site a link to information on how to obtain an application and application assistance.

Sec. 5. Minnesota Statutes 2006, section 256B.057, subdivision 8, is amended to read:

Subd. 8. **Children under age two.** Medical assistance may be paid for a child under two years of age whose countable family income is above 275 percent of the federal poverty guidelines for the same size family but less than or equal to ~~280~~ 305 percent of the federal poverty guidelines for the same size family.

EFFECTIVE DATE. This section is effective July 1, 2010, or upon federal approval, whichever is later.

Sec. 6. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) Families with children with family income equal to or less than ~~275~~ 300 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, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) ~~Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds $50,000.~~

~~(c)~~ Children formerly enrolled in medical assistance and automatically deemed eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt from the requirements of this section until renewal.

EFFECTIVE DATE. This section is effective July 1, 2010, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 7. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** (a) The definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 200 percent of the federal poverty guidelines.

(b) Effective July 1, 2009, the definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 215 percent of the federal poverty guidelines.

(c) Effective July 1, 2010, the definition of eligible persons includes all individuals and households with no children who have gross family incomes that are equal to or less than 300 percent of the federal poverty guidelines.

Sec. 8. Minnesota Statutes 2007 Supplement, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. If there is no change in circumstances, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. The designated sites shall forward the renewal forms to the commissioner. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) For single adults and households with no children formerly enrolled in general assistance medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3, the first period of eligibility begins the month the enrollee submitted the application or renewal for general assistance medical care.

(d) An enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month beyond the end of the current eligibility period, before being

disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the additional month.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2006, section 256L.05, is amended by adding a subdivision to read:

Subd. 6. **Delayed verification.** On the basis of information provided on the completed application, an applicant whose gross income is less than 90 percent of the applicable income standard and meets all other eligibility requirements, including compliance at the time of application with citizenship or nationality documentation requirements under section 256L.04, subdivision 10, must be determined eligible and enrolled upon payment of premiums according to subdivision 3. The applicant shall provide all required verifications within 60 days' notice of the eligibility determination, or eligibility shall be denied or canceled. Applicants who are denied or canceled for failure to provide all required verifications are not eligible for coverage using the delayed verification procedures specified in this subdivision for 12 months.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2006, section 256L.06, subdivision 3, is amended to read:

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 first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. ~~Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment~~ The commissioner shall waive premiums for coverage provided under this paragraph to persons disenrolled for nonpayment who reapply under section 256L.05, subdivision 3b. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. Minnesota Statutes 2007 Supplement, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 ~~and the four-month requirement in subdivision 3~~, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above ~~275~~ 300 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, or 300 percent of federal poverty guidelines on or after July 1, 2010, 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 following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(b) Notwithstanding paragraph (a), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

~~(c) Notwithstanding paragraphs (a) and (b), parents are not eligible for MinnesotaCare if gross household income exceeds $50,000 for the 12-month period of eligibility.~~

EFFECTIVE DATE. The effective date for the amendment to paragraph (a) related to the four-month requirement is effective January 1, 2009, or upon federal approval, whichever is later. The effective date for the amendment of paragraph (a) related to the expansion in eligibility to 300 percent of federal poverty guidelines, and the amendment to paragraph (c), are effective July 1, 2010.

Sec. 12. Minnesota Statutes 2006, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled ~~or for at least four months prior to application and renewal~~. Children enrolled in the original children's health plan and children in families with income equal to or less than 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

(2) requires a deductible of $100 or more per person per year; or

(3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of no health coverage does not apply to newborns.

(b) Medical assistance, general assistance medical care, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of ~~the four-month requirement described in~~ this subdivision.

~~(c)~~ 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 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.

~~(d)~~ (c) Applicants who were recipients of medical assistance or general assistance medical care within one month of application must meet the provisions of this subdivision and subdivision 2.

~~(e) Cost-effective health insurance that was paid for by medical assistance is not considered health coverage for purposes of the four-month requirement under this section, except if the insurance continued after medical assistance no longer considered it cost-effective or after medical assistance closed.~~

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 13. Minnesota Statutes 2007 Supplement, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross 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 gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. Until June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) ~~Families~~ Children in families whose gross income is above ~~275~~ 300 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

(c) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according to the affordability scale established in section 62U.08 with the exception that children in families with income at or below 150 percent of the federal poverty guidelines shall pay a monthly premium of $4. For purposes of this paragraph, and the affordability standard under section 62U.09, "minimum" means a monthly premium of $4.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later, except that the amendment to paragraph (b) related to the expansion in eligibility to 300 percent of federal poverty guidelines is effective July 1, 2010, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 14. Laws 2007, chapter 147, article 5, section 19, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective July 1, ~~2007, or upon federal approval, whichever is later~~ 2008.

Sec. 15. **REPEALER.**

Minnesota Statutes 2006, section 256L.15, subdivision 3, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval of the amendments to Minnesota Statutes, section 256L.15, subdivision 2, paragraph (c), whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 4
HEALTH INSURANCE PURCHASING AND AFFORDABILITY REFORM

Section 1. Minnesota Statutes 2007 Supplement, section 62J.495, is amended by adding a subdivision to read:

Subd. 3. **Interoperable electronic health record requirements.** To meet the requirements of subdivision 1, hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(a) The electronic health record must be certified by the Certification Commission for Healthcare Information Technology, or its successor. This criterion only applies to hospitals and health care providers whose practice setting is a practice setting covered by Certification Commission for Healthcare Information Technology certifications. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(b) A health care provider who is a prescriber or dispenser of controlled substances must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 2. **[62J.497] ELECTRONIC PRESCRIPTION DRUG PROGRAM.**

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

(a) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(b) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(c) "Electronic media" has the same meaning given this term under Code of Federal Regulations, title 45, part 160.103.

(d) "E-prescribing" means the transmission using electronic media, of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser.

(e) "Electronic prescription drug program" means a program that provides for e-prescribing.

(f) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(g) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(h) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(i) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(j) "NCPDP Formulary and Benefits Standard" means the National Council for Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0, October 2005.

(k) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version 8, Release 1 (Version 8.1), October 2005.

(l) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(m) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance under section 152.12, subdivision 1.

(n) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(o) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Subd. 2. **Requirements for electronic prescribing.** (a) Effective January 1, 2011, all providers, group purchasers, prescribers, and dispensers must establish and maintain an electronic prescription drug program that complies with the applicable standards

in this section for transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media.

(b) Nothing in this section requires providers, group purchasers, prescribers, or dispensers to conduct the transactions described in this section. If transactions described in this section are conducted, they must be done electronically using the standards described in this section. Nothing in this section requires providers, group purchasers, prescribers, or dispensers to electronically conduct transactions that are expressly prohibited by other sections or federal law.

(c) Providers, group purchasers, prescribers, and dispensers must use either HL7 messages or the NCPDP SCRIPT Standard to transmit prescriptions or prescription-related information internally when the sender and the recipient are part of the same legal entity. If an entity sends prescriptions outside the entity, it must use the NCPDP SCRIPT Standard or other applicable standards required by this section. Any pharmacy within an entity must be able to receive electronic prescription transmittals from outside the entity using the adopted NCPDP SCRIPT Standard. This exemption does not supersede any Health Insurance Portability and Accountability Act (HIPAA) requirement that may require the use of a HIPAA transaction standard within an organization.

(d) Entities transmitting prescriptions or prescription-related information where the prescriber is required by law to issue a prescription for a patient to a nonprescribing provider that in turn forwards the prescription to a dispenser are exempt from the requirement to use the NCPDP SCRIPT Standard when transmitting prescriptions or prescription-related information.

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. The NCPDP SCRIPT Standard shall be used to conduct the following transactions:

(1) get message transaction;

(2) status response transaction;

(3) error response transaction;

(4) new prescription transaction;

(5) prescription change request transaction;

(6) prescription change response transaction;

(7) refill prescription request transaction;

(8) refill prescription response transaction;

(9) verification transaction;

(10) password change transaction;

(11) cancel prescription request transaction; and

(12) cancel prescription response transaction.

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

Sec. 3. **[62U.01] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this section have the meanings given, unless otherwise specified.

Subd. 2. **Basket or baskets of care.** "Basket" or "baskets of care" means a collection of health care services that are paid separately under a fee-for-service system, but which are ordinarily combined by a provider in delivering a full diagnostic or treatment procedure to a patient.

Subd. 3. **Clinically effective.** "Clinically effective" means that the use of a particular health technology or service improves or prevents a decline in patient clinical status, as measured by medical condition, survival rates, and other variables, and that the use of the particular technology or service demonstrates a clinical or outcome advantage over alternative technologies or services. This definition shall not be used to exclude or deny technology or treatment necessary to preserve life on the basis of an individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency, or quality of life.

Subd. 4. **Cost-effective.** "Cost-effective" means that the economic costs of using a particular service, device, or health technology to achieve improvement or prevent a decline in a patient's health outcome are justified given the comparison to both the economic costs and the improvement or prevention of decline in patient health outcome resulting from the use of an alternative service, device, or technology, or from not providing the service, device, or technology.

Subd. 5. **Group purchaser.** "Group purchaser" has the meaning provided in section 62J.03.

Subd. 6. **Health plan.** "Health plan" means a health plan as defined in section 62A.011.

Subd. 7. **Health plan company.** "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

Subd. 8. **Participating provider.** "Participating provider" means a provider who has entered into a service agreement with a health plan company.

Subd. 9. **Provider or health care provider.** "Provider" or "health care provider" means a health care provider as defined in section 62J.03, subdivision 8.

Subd. 10. **Service agreement.** "Service agreement" means an agreement, contract, or other arrangement between a health plan company and a provider under which the provider agrees that when health services are provided for an enrollee, the provider shall not make a direct charge against the enrollee for those services or parts of services that are covered by the enrollee's contract, but shall look to the service plan corporation for the payment for covered services, to the extent they are covered.

Subd. 11. **State health care program.** "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Subd. 12. **Third-party administrator.** "Third-party administrator" means a vendor of risk-management services or an entity administering a self-insurance or health insurance plan under section 60A.23.

Sec. 4. **[62U.02] VALUE-BASED BENEFIT SET AND DESIGN.**

Subdivision 1. **Creation.** By October 15, 2009, the commissioner of health shall make recommendations to the legislature on the components and design of a value-based set of health benefits. The commissioner shall convene an advisory committee to assist in preparing recommendations. Prior to recommending the value-based benefit set and design, the commissioner and advisory committee shall convene public hearings throughout the state.

Subd. 2. **Operations of advisory committee.** The advisory committee shall consist of no more than 11 members. The members shall be appointed by the commissioner and must have expertise in benefit design and development in terms of outcomes, actuarial health care analysis, or knowledge relating to the analysis of the cost impact of coverage of specified benefits. The commissioner shall convene the first meeting on or before September 1, 2008, upon the appointment of the initial committee and must meet at least once a year, and at other times as necessary. The commissioner shall provide office

space, equipment and supplies, and technical support to the advisory committee. In establishing the benefit set, the committee shall consult with organizations with expertise in formulating scientifically based practice standards. The advisory committee shall be governed by section 15.059, except the committee shall not expire.

Subd. 3. **Immunity of liability.** No member of the advisory committee shall be held civilly liable for an act or omission by that member if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

Subd. 4. **Benefit set design.** (a) The value-based set of health benefits must provide individuals and families with access to a broad range of health care services, including preventive health care, without incurring severe financial loss as a result of serious illness or injury. The benefit set must include health care services, procedures, and diagnostic tests that are scientifically proven to be both clinically effective and cost effective. The benefit set may require differentiated co-pays and deductibles based upon the clinical effectiveness and cost effectiveness of a particular health care service. The advisory committee must consider including cost effective and clinically effective dental care, mental health services, chemical dependency treatment, vision care, language interpreter services, emergency transportation, and prescription drugs. The committee shall consider cultural, ethnic, and religious values and beliefs to ensure that the health care needs of all Minnesota residents are addressed in the benefit set.

(b) The benefit set must identify and include the following services with minimal or no cost-sharing requirements, if the committee determines that the savings and health quality improvements associated with broad access are equal to or greater than the cost of providing the services: preventive services, chronic care coordination, early diagnostic tests, and outpatient care for asthma, heart disease, diabetes, and depression.

(c) The benefit set shall, to the extent possible, be designed to be affordable to Minnesotans consistent with the affordability standard established in section 62U.09.

(d) The benefit design must establish a limited number of maximum cost-sharing variations based upon deductibles and maximum out-of-pocket costs. There must be no maximum lifetime benefit.

(e) The commissioners of human services and finance shall, to the extent possible, consider incorporating the benefit design into the state public health care programs and the state employee group insurance program.

(f) The commissioners of health and commerce shall report to the legislature on necessary changes needed to current mandated benefit sets to incorporate the benefit design developed under this section.

Subd. 5. **Continued review.** The commissioner and the committee shall review the benefit set and design on an ongoing periodic basis and shall adjust the benefit set and design as necessary, to ensure that the benefit set and design continues to be safe, effective, and scientifically based.

Sec. 5. **[62U.03] HEALTH TECHNOLOGY ASSESSMENT REVIEW.**

The commissioner of health , in consultation with the Health Advisory Council, the Institute for Clinical Systems, and practicing health care providers who either use health technology in their scope of practice or have an expertise in health technology, shall review the health technology assessments of new and existing health technologies that have been conducted by existing programs, including but not limited to, the state of Washington's health technology assessment program and the Medicaid Evidence-Based Decisions Project for inclusion to the value-based benefit set and design under section 62U.02.

Sec. 6. **[62U.04] PAYMENT RESTRUCTURING; INCENTIVE PAYMENTS BASED ON QUALITY OF CARE.**

Subdivision 1. **Development.** (a) The commissioner of health shall develop a standardized set of measures by which to assess the quality of health care services offered by health care providers, including health care providers certified as health care homes under section 256B.0751. Quality measures must be based on medical evidence and be developed through a process in which providers participate. The measures shall be used for the quality incentive payment system developed in subdivision 2 and must:

(1) include uniform definitions, measures, and forms for submission of data, to the greatest extent possible;

(2) seek to avoid increasing the administrative burden on health care providers;

(3) be initially based on existing quality indicators for physician and hospital services, which are measured and reported publicly by quality measurement organizations including Minnesota Community Measurement and specialty societies;

(4) place a priority on measures of health care outcomes, rather than process measures, wherever possible; and

(5) incorporate measures for primary care, including preventive services, coronary artery and heart disease, diabetes, asthma, depression, and other measures as determined by the commissioner.

(b) The measures shall be reviewed at least annually by the commissioner.

Subd. 2. **Quality incentive payments.** (a) By July 1, 2009, the commissioner shall develop a system of quality incentive payments under which providers are eligible

for quality-based payments that are in addition to existing payment levels, based upon a comparison of provider performance against specified targets, including improvement over time. The targets must be based upon and consistent with the quality measures established under subdivision 1.

(b) To the extent possible, the payment system must adjust for variations in patient population, in order to reduce incentives to health care providers to avoid high-risk patients or populations.

(c) The requirements of section 62Q.101 do not apply under this incentive payment system.

Subd. 3. **Quality transparency.** The commissioner shall establish standards for measuring health outcomes, establish a system for risk adjusting quality measures, and issue annual public reports on provider quality beginning July 1, 2010. By January 1, 2010, physician clinics and hospitals shall submit standardized electronic information on the outcomes and processes associated with patient care to the commissioner or the commissioner's designee. In addition to measures of care processes and outcomes, the report may include other measures designated by the commissioner, including, but not limited to, care infrastructure and patient satisfaction. The commissioner shall ensure that any quality data reporting requirements established under this subdivision are not duplicative of publicly reported, community-wide quality reporting activities currently under way in Minnesota. Nothing in this subdivision is intended to replace or duplicate current privately supported activities related to quality measurement and reporting in Minnesota.

Subd. 4. **Contracting.** The commissioner may contract with a private entity or consortium of private entities to complete the tasks in subdivisions 1, 2, and 3. The private entity or consortium must be nonprofit and have governance that includes representatives from the following stakeholder groups: health care providers, health plan companies, consumers, employers or other health care purchasers, and state government. No one stakeholder group shall have a majority of the votes on any issue or hold extraordinary powers not granted to any other governance stakeholder.

Subd. 5. **Implementation.** (a) By January 1, 2010, health plan companies shall use the standardized quality measures established under this section and shall not require providers to use and report health plan company-specific quality and outcome measures.

(b) By July 1, 2010, the commissioner of human services shall implement this incentive payment system for all enrollees in state health care programs consistent with relevant state and federal statute and rule.

(c) By July 1, 2010, the commissioner of finance shall implement this incentive payment system for all participants in the state employee group insurance program.

(d) By July 1, 2010, all health plan company incentive based performance payment systems shall comply with subdivision 2 for all participating providers.

Sec. 7. **[62U.05] PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS.**

By July 1, 2010, health plan companies shall integrate health care homes into their provider networks and shall develop a payment system that provides per-person care coordination payments to health care providers for providing care coordination services and directly managing onsite or employing care coordinators for their members who choose to enroll in health care homes certified by the commissioners of health and human services under section 256B.0751. Health plan companies shall develop payment conditions and terms for the care coordination fee for health care homes participating in their network in a manner that is consistent with the system developed under section 256B.0751. Nothing in this section shall restrict the ability of health plan companies to selectively contract with health care providers, including health care homes.

Sec. 8. **[62U.06] PAYMENT REFORM TO REDUCE HEALTH CARE COSTS AND IMPROVE QUALITY.**

Subdivision 1. **Development of uniform standards.** The commissioner of health shall develop the uniform standards identified in this section needed to implement on a broad scale innovative payment reform that rewards quality and efficiency. The development of the standards must be completed by January 1, 2010.

Subd. 2. **Calculation of health care costs and quality.** The commissioner shall develop a method of calculating providers' relative cost of care, defined as a measure of health care spending including resource use and unit prices, and relative quality of care. In developing this method, the commissioner must address the following issues:

(1) provider attribution of costs and quality;

(2) appropriate adjustment for outlier or catastrophic cases;

(3) appropriate risk adjustment to reflect differences in the demographics and health status across provider patient populations, using generally accepted and transparent risk adjustment methodologies;

(4) specific types of providers that should be included in the calculation;

(5) specific types of services that should be included in the calculation;

(6) appropriate adjustment for variation in payment rates;

(7) the appropriate provider level for analysis;

(8) payer mix adjustments, including variation across providers in the percentage of revenue received from government programs; and

(9) other factors that the commissioner determines are needed to ensure validity and comparability of the analysis.

Subd. 3. **Provider peer grouping.** (a) The commissioner shall develop a peer grouping system for providers based on a measure that incorporates both provider risk-adjusted cost of care and quality of care for specific conditions as determined by the commissioner. In developing this system, the commissioner shall consult and coordinate with health care providers, health plan companies, state agencies, and organizations that work to improve health care quality in Minnesota. However, in the final development of this peer grouping system, the commissioner shall not contract with any private entity, organization, or consortium of entities that has or will have a direct financial interest in the outcome of this system.

(b) Beginning June 1, 2010, the commissioner shall disseminate information to providers on their cost of care, resource use, quality of care, and the results of the grouping developed under this subdivision in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. The provider shall have 21 days to review the data for accuracy.

(c) The commissioner shall establish an appeals process to resolve disputes from providers regarding the accuracy of the data used to develop analyses or reports.

(d) Beginning September 1, 2010, the commissioner shall, no less than annually, publish information on providers' cost, quality, and the results of the peer grouping process. The results that are published must be on a risk-adjusted basis.

Subd. 4. **Encounter data.** (a) Beginning July 1, 2009, and every six months thereafter, all health plan companies and third-party administrators shall submit encounter data to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home; and

(3) except for the identifier described in clause (2), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under section 62J.536.

(b) The commissioner, or the commissioner's designee, shall only use the data submitted under paragraph (a) for the purpose of carrying out its responsibilities in this section, and must maintain the data that it receives according to the provisions of this section.

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commissioner, or the commissioner's designee, shall not publish analyses or reports that identify, or could potentially identify, individual patients.

Subd. 5. **Pricing data.** (a) Beginning July 1, 2009, and annually on January 1 thereafter, all health plan companies and third-party administrators shall submit data on their contracted prices with health care providers to a private entity designated by the commissioner of health for the purposes of performing the analyses required under this subdivision. The data shall be submitted in the form and manner specified by the commissioner of health.

(b) The commissioner shall only use the data submitted under this subdivision for the purpose of carrying out its responsibilities under this section.

(c) Data collected under this subdivision are nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

Subd. 6. **Contracting.** The commissioner may contract with a private entity or consortium of entities to develop the standards. The private entity or consortium must be nonprofit and have governance that includes representatives from the following stakeholder groups: health care providers, health plans, hospitals, consumers, employers or other health care purchasers, and state government. The entity or consortium must ensure that the representatives of stakeholder groups in the aggregate reflect all geographic areas of the state. No one stakeholder group shall have a majority of the votes on any issue or hold extraordinary powers not granted to any other governance stakeholder.

Subd. 7. **Provider innovation to reduce health care costs and improve quality.** (a) Nothing in this section shall prohibit group purchasers and health care providers, upon mutual agreement, from entering into arrangements that establish package prices for a comprehensive set of services or separately for the cost of care for specific health conditions in addition to the baskets of care established in section 62U.07, in order to give providers the flexibility to innovate on ways to reduce health care costs while improving overall quality of care and health outcomes.

(b) The commissioner of health may convene working groups of private sector payers and health care providers to discuss and develop new strategies for reforming health care payment systems to promote innovative care delivery that reduces health care costs and improves quality.

Subd. 8. **Uses of information.** (a) By January 1, 2011:

(1) the commissioner of finance shall use the information and methods developed under subdivision 3 to strengthen incentives for members of the state employee group insurance program to use high-quality, low-cost providers;

(2) the commissioner of human services shall use the information and methods developed under subdivision 3 to establish a payment system that:

(i) rewards high-quality, low-cost providers;

(ii) creates enrollee incentives to receive care from high-quality, low-cost providers; and

(iii) fosters collaboration among providers to reduce cost shifting from one part of the health continuum to another;

(3) all political subdivisions, as defined in section 13.02, subdivision 11, that offer health benefits to their employees must offer plans that differentiate providers on their cost and quality performance and create incentives for members to use better-performing providers;

(4) all health plan companies shall use the information and methods developed under subdivision 3 to develop products that encourage consumers to use high-quality, low-cost providers; and

(5) health plan companies that issue health plans in the individual market or the small employer market must offer at least one health plan that uses the information developed under subdivision 3 to establish financial incentives for consumers to choose high-quality, low-cost providers through enrollee cost-sharing or selective provider networks.

(b) By January 1, 2011, the commissioner of health shall report to the governor and the legislature on recommendations to encourage health plan companies to promote widespread adoption of products that encourage the use of high-quality, low-cost providers.

The commissioner's recommendations may include tax incentives, public reporting of health plan performance, regulatory incentives or changes, and other strategies.

(c) The commissioner of health shall consult with an advisory group comprised of employers and consumers to utilize the cost and provider quality information developed under subdivision 3 to identify ways to improve overall health care costs and quality for residents of Minnesota.

Sec. 9. **[62U.07] PROVIDER PRICING FOR BASKETS OF CARE.**

Subdivision 1. **Establishment of definitions.** (a) The commissioner of health shall establish uniform definitions for baskets of care beginning with a minimum of 15 baskets of care. In selecting health conditions for which baskets of care should be defined, the commissioner shall consider coronary artery and heart disease, diabetes, asthma, and depression. In selecting health conditions, the commissioner shall also consider the prevalence of the health conditions, the cost of treating the health conditions, and the potential for innovations to reduce cost and improve quality resulting from establishing a basket of care for a specific health condition.

(b) The commissioner shall convene one or more work groups to assist in establishing these definitions. Each work group shall include members appointed by statewide associations representing relevant health care providers and health plan companies, and organizations that work to improve health care quality in Minnesota.

(c) The baskets of care shall incorporate a patient-directed, decision-making support model.

(d) The commissioner shall submit recommendations to the Legislative Commission on Health Care Access on establishing a uniform definition of a basket of total cost of care.

Subd. 2. **Package prices.** (a) Beginning January 1, 2010, health care providers may establish package prices for the baskets of care defined under subdivision 1.

(b) Beginning January 1, 2010, no health care provider or group of providers that has established a package price for a basket of care under this section shall vary the payment amount that the provider accepts as full payment for a health care service based upon the identity of the payer, upon a contractual relationship with a payer, upon the identity of the patient, or upon whether the patient has coverage through a group purchaser. This paragraph applies only to health care services provided to Minnesota residents or to non-Minnesota residents who obtain health insurance through a Minnesota employer. This paragraph does not apply to a variation based upon a payer being a governmental entity, to workers' compensation, or no-fault automobile insurance payments. This paragraph does not affect the right of a provider to provide charity care or care for a reduced price

due to financial hardship of the patient or due to the patient being a relative or friend of the provider.

Subd. 3. **Quality measurements for baskets of care.** (a) The commissioner shall establish quality measurements for the defined baskets of care by December 31, 2009. The commissioner may contract with an organization that works to improve health care quality to make recommendations about the use of existing measures or establishing new measures where no measures currently exist.

(b) Beginning July 1, 2010, the commissioner shall publish comparative price and quality information on the baskets of care in a manner that is easily accessible and understandable to the public, as this information becomes available.

Sec. 10. **[62U.08] COORDINATION; LEGISLATIVE OVERSIGHT ON PAYMENT RESTRUCTURING.**

Subdivision 1. **Coordination.** In carrying out the responsibilities of this chapter, the commissioner of health shall ensure that the activities and data collection are implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and implement methods to streamline data collection in order to reduce public and private sector administrative costs.

Subd. 2. **Legislative oversight.** Beginning December 1, 2008, the commissioner of health shall submit to the Legislative Commission on Health Care Access periodic progress reports on the implementation of this chapter and sections 256B.0751 to 256B.0753 that includes, but is not limited to, the following:

(1) the standardized set of measures that are to be used to access the quality of health care services offered by health care providers developed under section 62U.04;

(2) the identification of the evidence supporting each measure developed under section 62U.04 as an effective method of improving the quality of patient care;

(3) the contract terms and the identity of the consortium if the commissioner contracts with a private entity or consortium of private entities as permitted under sections 62U.04 and 62U.06;

(4) methodology for peer grouping of providers under section 62U.06, subdivision 3;

(5) methodology for calculating providers' relative cost of care under section 62U.06, subdivision 2; and

(6) the uniform definitions of baskets of care under section 62U.07.

Sec. 11. **[62U.09] AFFORDABILITY STANDARD.**

Subdivision 1. **Definition of affordability.** For purposes of this section, coverage is "affordable" if the sum of premiums, deductibles, and other out-of-pocket costs paid by an individual or family for health coverage does not exceed the applicable percentage of the individual or family's gross monthly income specified in subdivision 2.

Subd. 2. **Affordability standard.** The following affordability standard is established for individuals and households with gross family incomes of 400 percent of the federal poverty guidelines or less:

Federal Poverty Guideline Range	**Percent of Average Gross Monthly Income**
0-45%	minimum
46-54%	1.1%
55-81%	1.4%
82-109%	1.9%
110-136%	2.6%
137-164%	3.4%
165-191%	4.4%
192-219%	5.2%
220-248%	5.9%
249-274%	6.5%
275-300%	7.0%
301-325%	7.7%
326-350%	8.4%
351-375%	9.2%
376-400%	10.0%

Subd. 3. **Application.** The affordability standard in this section shall apply only to subsidies under the MinnesotaCare program and the employee subsidy program established under section 62U.10. Nothing in this section shall be construed to limit or restrict the percentage of premiums, deductibles, and other out-of-pocket costs paid by an individual or family in the private commercial health care coverage market.

Sec. 12. **[62U.10] EMPLOYEE SUBSIDIES FOR HEALTH COVERAGE.**

Subdivision 1. **Development of subsidy program.** The commissioner of health, in coordination with the commissioner of human services, shall develop a plan and submit recommendations to the legislature by January 15, 2010, for a subsidy program for eligible individuals and employees with access to employer-subsidized health coverage. The plan may include direct subsidies or tax credits and deductions, including refundable tax credits, or a combination. For purposes of this section, employer-subsidized health coverage has the meaning provided in section 256L.07, subdivision 2, paragraph (c).

Subd. 2. **Eligible employees and dependents; incomes not exceeding 300 percent of federal poverty guidelines.** In order to be eligible for a subsidy under this plan, an employee or dependent with a gross household income that does not exceed 300 percent of the federal poverty guidelines must:

(1) be covered by employer-subsidized health coverage, as defined in section 256L.07, subdivision 2, paragraph (c), that meets the value-based benefit set and design requirements established under section 62U.02; and

(2) meet all eligibility criteria for the MinnesotaCare program established under chapter 256L, except for the requirements related to:

(i) no access to employer-subsidized coverage under section 256L.07, subdivision 2; and

(ii) no other health coverage under section 256L.07, subdivision 3.

Subd. 3. **Eligible individuals, employees and dependents; incomes greater than 300 percent but not exceeding 400 percent of federal poverty guidelines.** In order to be eligible for a subsidy under this plan, an individual, employee, or dependent with a gross household income that is greater than 300 percent but does not exceed 400 percent of the federal poverty guidelines must:

(1) purchase or be covered by health coverage that meets the value-based benefit set and design requirements established under section 62U.02; and

(2) meet all eligibility criteria for the MinnesotaCare program established under chapter 256L, except for the requirements related to:

(i) no access to employer-subsidized coverage under section 256L.07, subdivision 2;

(ii) no other health coverage under section 256L.07, subdivision 3; and

(iii) gross household income under section 256L.04, subdivisions 1 and 7.

Subd. 4. **Amount of subsidy.** The subsidy included in this plan must equal the amount the individual or employee is required to pay for health coverage for the employee and any dependents, including premiums, deductibles, and other cost sharing, minus an amount based on the affordability standard specified in section 62U.09. The maximum subsidy must not exceed the amount of the subsidy that would have been provided under the MinnesotaCare program, if the individual or employee and any dependents were eligible for that program.

Subd. 5. **Payment of subsidy.** The subsidy amount under this plan for an individual or employee and any dependents to the individual's or employee's health plan company, shall be credited toward the individual's or employee's share of premium. Any additional amount paid to the individual's or employee's health plan company that exceeds the

individual's or employee's share of premium must be credited first toward the individual's or employee's deductible and then toward any other cost-sharing obligation.

Sec. 13. **[62U.11] PROJECTED AND ACTUAL HEALTH CARE SPENDING.**

Subdivision 1. **Projected spending baseline.** (a) The commissioner of health shall calculate the annual projected total health care spending for the state and establish a health care spending baseline beginning for the calendar year 2008 and for the next ten years based on the annual projected growth in spending.

(b) In establishing the health care spending baseline, the commissioner shall use the Center for Medicare and Medicaid Services forecast for total growth in national health care expenditures, and adjust this forecast to reflect the demographics, health status, and other factors deemed necessary by the commissioner. The commissioner shall contract with an actuarial consultant to make recommendations as to the adjustments needed to specifically reflect projected spending for Minnesota residents.

(c) On an annual basis, the commissioner may adjust the projected baseline as necessary to reflect any updated federal projections or account for unanticipated changes in federal policy.

(d) Medicare and long-term care spending must not be included in the calculations required under this section.

Subd. 2. **Actual spending.** By February 15 of each year, beginning February 15, 2010, the commissioner shall determine the actual private and public health care expenditures for the calendar year two years prior to the current calendar year based on data collected under chapter 62J and shall determine the difference between the projected spending as determined under subdivision 1 and the actual spending for that year. The actual spending must be certified by an independent actuarial consultant.

Subd. 3. **Publication of spending.** By February 15 of each year, beginning February 15, 2010, the commissioner shall publish in the State Register the projected spending baseline, including any adjustments, and the actual spending for the calendar year two years prior to the current calendar year.

Sec. 14. **[62U.12] HEALTH CARE REFORM REVIEW COUNCIL.**

Subdivision 1. **Establishment.** The Health Care Reform Review Council is established for the purpose of periodically reviewing the progress of implementation of this chapter and sections 256B.0751 to 256B.0753.

Subd. 2. **Members.** (a) The Health Care Reform Review Council shall consist of ten members who are appointed as follows:

(1) two members appointed by the Minnesota Medical Association, at least one of whom must represent rural physicians;

(2) one member appointed by the Minnesota Nurses Association;

(3) two members appointed by the Minnesota Hospital Association, at least one of whom must be a rural hospital administrator;

(4) one member appointed by the Minnesota Academy of Physician Assistants;

(5) one member appointed by the Minnesota Business Partnership;

(6) one member appointed by the Minnesota Chamber of Commerce;

(7) one member appointed by the SEIU Minnesota State Council; and

(8) one member appointed by the AFL-CIO.

(b) If a member is no longer able or eligible to participate, a new member shall be appointed by the entity that appointed the outgoing member.

Subd. 3. **Operations of council.** (a) The commissioner of health shall convene the first meeting of the council on or before January 15, 2009, following the initial appointment of the members and the advisory council must meet at least quarterly thereafter.

(b) The council is governed by section 15.059, except that members shall not receive per diems and the council does not expire.

(c) The commissioner of health shall provide staff, administrative support, and office space to the council.

Subd. 4. **Responsibilities of council.** The council shall periodically review the implementation of this chapter and sections 256B.0571 to 256B.0573, including but not limited to:

(1) the development and implementation of certification, process, outcome, and quality standards for health care homes;

(2) development and implementation of payment restructuring and payment reform under sections 62U.04, 62U.05, 62U.06, and 62U.07; and

(3) development of the plan and recommendations for providing subsidies to employees for health coverage under section 62U.10.

Sec. 15. **[62U.13] SECTION 125 PLANS.**

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

(a) "Employee" means an employee currently on an employer's payroll other than a retiree or disabled former employee.

(b) "Employer" means a person, firm, corporation, partnership, association, business trust, or other entity employing one or more persons, including a political subdivision of the state, filing payroll tax information on the employed person or persons.

(c) "Section 125 Plan" means a cafeteria or premium-only plan under section 125 of the Internal Revenue Code that allows employees to pay for health coverage premiums with pretax dollars.

Subd. 2. **Section 125 Plan requirement.** (a) Effective July 1, 2009, all employers with 11 or more current full-time equivalent employees in this state shall establish and maintain a Section 125 Plan to allow their employees to purchase individual market or employer-based health coverage with pretax dollars. Nothing in this section requires employers to offer or purchase group health coverage for their employees. The following employers are exempt from the Section 125 Plan requirement:

(1) employers that offer a health plan as defined in section 62A.011, subdivision 3, that is group coverage;

(2) employers that provide self-insurance as defined in section 62E.02; or

(3) employers that have no employees who are eligible to participate in a Section 125 Plan.

(b) Notwithstanding paragraph (a), an employer that has been certified by a licensed insurance producer as having received education and information on the benefits and advantages of offering Section 125 Plans is not required to establish a Section 125 Plan and may opt out of the requirement to establish a Section 125 Plan by sending a form to the commissioner of commerce. The commissioner of commerce shall create a simple check-box form for employers to opt out. The commissioner of commerce shall make the form available through their Web site by April 1, 2009.

Subd. 3. **Employer requirements.** (a) Employers that do not offer a health plan as defined in section 62A.011, subdivision 3, that is group coverage and are required to offer or choose to offer a Section 125 Plan shall:

(1) allow employees to purchase an individual market health plan for themselves and their dependents;

(2) allow employees to choose any insurance producer licensed in accident and health insurance under chapter 60K to assist them in purchasing an individual market health plan;

(3) upon an employee's request, deduct premium amounts on a pretax basis in an amount not to exceed an employee's wages, and remit these employee payments to the health plan; and

(4) provide written notice to employees that individual market health plans purchased by employees through payroll deduction are not employer-sponsored or administered.

(b) Employers shall be held harmless from any and all claims related to the individual market health plans purchased by employees under a Section 125 Plan.

Sec. 16. **[256B.0751] PAYMENT REFORM.**

Subdivision 1. **Quality incentive payments.** The commissioner of human services shall implement quality incentive payments as required under section 62U.04. This does not limit the ability of the commissioner of human services to establish by contract and monitor, as part of its quality assurance obligations for state health care programs, outcome and performance measures for nonmedical services and health issues likely to occur in low-income populations or racial or cultural groups disproportionately represented in state health care program enrollment, that would likely be underrepresented when using traditional measures that are based on longer-term enrollment.

Subd. 2. **Payment reform.** The commissioner of human services shall establish a payment system to reduce health care costs and improve quality as required under section 62U.06.

Sec. 17. **HIGH-DEDUCTIBLE HEALTH PLAN OPTION.**

The commissioner of finance shall consider including an option that is compatible with the definition of a high-deductible health plan in section 223 of the Internal Revenue Code in the health insurance benefit plans offered under the managerial plan in Minnesota Statutes, section 43A.18, subdivision 3.

Sec. 18. **STUDY OF UNIFORM CLAIMS REVIEW PROCESS.**

The commissioner of health shall establish a work group including representatives of the Minnesota Hospital Association, Minnesota Medical Association, and Minnesota Council of Health Plans to make recommendations on the potential for reducing claims adjudication costs of health care providers and health plan companies by adopting more uniform payment methods, and the potential impact of establishing uniform prices that would replace current prices negotiated individually by providers with separate payers. The work group shall make its recommendations to the commissioner by January 1, 2010, and shall identify specific action steps needed to achieve the recommendations.

ARTICLE 5
APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

		2009		Total
General Fund	$	403,000	$	403,000
Health Care Access Fund		12,883,000		12,883,000
Total	**$**	**13,286,000**	**$**	**13,286,000**

Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2007, chapter 147, article 19, or other law to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal year indicated for each purpose. The figure "2009" used in this article means that the addition to or subtraction from the appropriation listed under it is available for the fiscal year ending June 30, 2009.

	APPROPRIATIONS Available for the Year Ending June 30
	2009
Sec. 3. **HUMAN SERVICES**	
Subdivision 1. **Total Appropriation**	**$ 6,175,000**

Appropriations by Fund

	2009
General	1,227,000
Health Care Access	4,948,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Children and Economic Assistance Management**

Health Care Access	6,000

This is a onetime appropriation.

Subd. 3. **Basic Health Care Grants**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **MinnesotaCare Grants**

Health Care Access 1,301,000

(b) **Other Health Care Grants**

Health Care Access 200,000

Primary Care Physician Rate Increases.
(1) Of the general fund appropriation, $200,000 is to the commissioner for the medical assistance reimbursement rate increase described in Minnesota Statutes, section 256B.766.

(2) Notwithstanding Minnesota Statutes, section 295.581, the commissioner of finance shall reimburse the medical assistance general fund account from the health care access fund the amount of general fund expenditures for this activity. The amount reimbursed under this paragraph is appropriated to the commissioner.

Subsidies for Employer-Subsidized Health Coverage. For the biennium beginning July 1, 2009, base level funding for the subsidy program described in Minnesota Statutes, section 62U.10, shall be $20,000,000 from the health care access fund for the first year and $35,000,000 from the health care access fund for the second year.

Base Adjustment. The health care access fund base is increased by $3,000,000 in fiscal year 2010 and increased by $5,000,000 in fiscal year 2011.

Subd. 4. **Health Care Management**

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **Health Care Policy Administration**

General	1,008,000
Health Care Access	282,000

Base Adjustment. The health care access fund is decreased by $89,000 in fiscal year 2010 and decreased by $272,000 in fiscal year 2011.

Base Adjustment. The general fund base is decreased by $80,000 in both fiscal years 2010 and 2011.

Department of Education Computer System. $50,000 is from the health care access fund for the commissioner to enter into an agreement with the Department of Education for the modification of the department's computer system to implement Minnesota Statutes, section 124D.1115. This is a onetime appropriation.

Public dental coverage program study. (1) Of the health care access fund appropriation, $50,000 in fiscal year 2009 is for the commissioner of human services to undertake a study to determine whether alternative approaches to offering dental coverage to public program enrollees would result in:

(i) improved access to dental care;

(ii) cost savings to providers and the department; and

(iii) improved quality and outcomes of care.

Alternatives considered must include moving to a single dental plan administrator, retaining the current model, and other innovative approaches. Issues relating to chronic disease

management, medical and dental interface, plan payment approaches, and provider payment should also be addressed. The report must make a recommendation on whether to alter the current approach to contracting for dental services, and include a detailed plan on how to implement any changes. The commissioner shall consult with dentists, safety net dental providers, dental plans, health plans and county-based purchasing organizations, patients and advocates, and other interested parties in developing their findings and recommendations.

(2) By December 15, 2008, the commissioner of human services shall report findings and recommendations to the chairs of the house of representatives and senate committees having jurisdiction over health and human services policy and finance.

(b) **Health Care Operations**

General	219,000
Health Care Access	2,355,000

This is a onetime appropriation.

Incentive Program and Outreach Grants. Of the appropriation for the Minnesota health care outreach program in Laws 2007, chapter 147, article 19, section 3, subdivision 7, paragraph (b):

(1) $400,000 in fiscal year 2009 from the general fund and $200,000 in fiscal year 2009 from the health care access fund are for the incentive program under Minnesota Statutes, section 256.962, subdivision 5. For the biennium beginning July 1, 2009, base level funding for this activity shall be $360,000

from the general fund and $160,000 from the health care access fund; and

(2) $100,000 in fiscal year 2009 from the general fund and $50,000 in fiscal year 2009 from the health care access fund are for the outreach grants under Minnesota Statutes, section 256.962, subdivision 2. For the biennium beginning July 1, 2009, base level funding for this activity shall be $90,000 from the general fund and $40,000 from the health care access fund.

Outreach Funding. (1) Of the health care access fund appropriation, $100,000 is for the incentive program under Minnesota Statutes, section 256.962, subdivision 5. This is in addition to the base level fund for the biennium beginning July 1, 2009. For the fiscal year beginning July 1, 2011, appropriations for this activity shall be from the health savings reinvestment fund.

(2) Notwithstanding Minnesota Statutes, section 295.581, the commissioner of finance shall reimburse the medical assistance general fund account from the health care access fund by $701,000 in fiscal year 2010 and $1,527,000 in fiscal year 2011 for the cost to the general fund for the increase in enrollment to the medical assistance program for families with children due to the outreach efforts.

Base Adjustment. The health care access fund base is decreased by $387,000 in fiscal year 2010 and increased by $642,000 in fiscal year 2011.

Subd. 5. **Continuing Care Management**

Health Care Access 804,000

Long-Term Care Worker Health Coverage Study. (a) Of the health care access fund appropriation, $804,000 is for the commissioner to study and report to the legislature by December 15, 2008, with recommendations for a rate increase to long-term care employers dedicated to the purchase of employee health insurance in the private market. The commissioner shall collect necessary actuarial data, employment data, current coverage data, and other needed information.

(b) The commissioner shall develop cost estimates for three levels of insurance coverage for long-term care workers:

(1) the coverage provided to state employees;

(2) the coverage provided to MinnesotaCare enrollees; and

(3) the benefits provided under an "average" private market insurance product, but with a deductible limited to $100 per person.

Premium cost sharing, waiting periods for eligibility, definitions of full- and part-time employment, and other parameters under the three options must be identical to those under the state employees' health plan.

(c) For purposes of this section, a long-term care worker is a person employed by a nursing facility, an intermediate care facility for persons with developmental disabilities, or a service provider that:

(1) is eligible under Laws 2007, chapter 147, article 7, section 71; and

(2) provides long-term care services.

The commissioner may recommend a different definition of long-term care worker if this definition presents insurmountable implementation issues.

(d) The recommendations must include measures to:

(1) ensure equitable treatment between employers that currently have different levels of expenditure for employee health insurance costs; and

(2) enforce the requirement that the rate increase be expended for the intended purpose.

This is a onetime appropriation.

Sec. 4. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ 7,111,000**

Appropriations by Fund

	2009
Health Care Access	7,935,000
General	(824,000)

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Community and Family Health Promotion**

Health Care Access 152,000

$152,000 in fiscal year 2009 is for statewide health saving research and measurement.

Statewide Health Improvement Program.

The health care access fund base shall be increased by $19,587,000 in fiscal year 2010 and $26,175,000 in fiscal year 2011 for

grants to local communities in accordance with Minnesota Statutes, section 145.986, subdivision 2; $205,000 in fiscal year 2010 and $424,000 in fiscal year 2011 is for staffing; $22,000 in fiscal year 2010 and $42,000 in fiscal year 2011 is for operating costs; $150,000 in fiscal year 2010 and $300,000 in fiscal year 2011 is for contracts for evaluation; and $36,000 in fiscal year 2010 and $60,000 in fiscal year 2011 is for administrative costs. The base for this program in fiscal year 2012 is $0.

Subd. 3. **Policy, Quality, and Compliance**

Health Care Access	7,783,000
General	(824,000)

Open Door Health Center. Of the health care access fund appropriation, $350,000 is to be awarded as a grant to the Open Door Health Center to act as bridge funding to meet the demand for health care services in medically underserved areas. This is a onetime appropriation.

Of this appropriation, $84,000 is for the commissioner to make recommendations to the legislature on community benefit standards to be required of nonprofit health plan companies doing business in the state. The expectations of the community benefits provided and reported should be related to the statutory expectations in Minnesota Statutes, sections 62C.01 and 62D.01, and focus on supporting public health, improving the art and science of medical care, and addressing the need for financial assistance to access ongoing coverage, and not related to general

philanthropic endeavors. The commissioner shall seek public input regarding the range of options to be explored and the accountability measures.

The recommendations must include a procedure by which each nonprofit health plan company would periodically and uniformly report to the state and to the public regarding the company's compliance with the requirements.

The commissioner shall recommend a fair and effective enforcement and remediation mechanism. This is a onetime appropriation.

Federally Qualified Health Centers. Of the health care access fund appropriation, $2,824,000 is for subsidies to federally qualified health centers under Minnesota Statutes, section 145.9269. The health care access fund base shall be $3,500,000 for fiscal years 2010 and 2011.

The general fund appropriation for this program shall be reduced by $824,000 for fiscal year 2009, and by $1,500,000 in both fiscal years 2010 and 2011.

Base Adjustment. The health care access fund base shall be further reduced by $4,104,000 in fiscal year 2010 and $4,323,000 in fiscal year 2011.

Sec. 5. **SUNSET OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2009, unless a different expiration date is specified.

Sec. 6. **EFFECTIVE DATE.**

The provisions in this article are effective July 1, 2008, unless a different effective date is specified.

APPENDIX
Article locations in H3391-6

256L.15 PREMIUMS.

Subd. 3. **Exceptions to sliding scale.** Children in families with income at or below 150 percent of the federal poverty guidelines pay a monthly premium of $4.