State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 4119

03/04/2020 Authored by Mann, Hausman, Bierman, Jordan, Schultz and others
The bill was read for the first time and referred to the Committee on Commerce

A bill for an act

relating to health; expanding eligibility for MinnesotaCare; expanding the use of integrated health partnerships and modifying service delivery; increasing provider payment rates; modifying enrollee premiums; requiring an implementation plan; modifying benefit coverage requirements for joint self-insurance plans; establishing the MinnesotaCare Advisory Council; amending Minnesota Statutes 2018, sections 62H.04; 62H.18, subdivision 9; 62U.04, subdivision 11; 256L.03, subdivision 1; 256L.04, subdivisions 1, 1c, 7; 256L.07, subdivision 1; 256L.11, by adding a subdivision; 256L.15, subdivision 2, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 256L; repealing Minnesota Statutes 2018, sections 256L.01, subdivision 7; 256L.07, subdivision 2; 256L.11, subdivisions 1, 3, 4; 256L.12; 256L.121, subdivisions 1, 2.

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

Section 1. Minnesota Statutes 2018, section 62H.04, is amended to read:

62H.04 COMPLIANCE WITH OTHER LAWS.

(a) A joint self-insurance plan is subject to the requirements of chapters 62A, 62E, 62L, and 62Q, and sections 72A.17 to 72A.32 unless otherwise specifically exempt. A joint self-insurance plan must pay assessments made by the Minnesota Comprehensive Health Association, as required under section 62E.11.

~~(b) A joint self-insurance plan is exempt from providing the mandated health benefits described in chapters 62A, 62E, 62L, and 62Q if it otherwise provides the benefits required under the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001, et seq., for all employers and not just for the employers with 50 or more employees who are covered by that federal law.~~

~~(c)~~ (b) A joint self-insurance plan is exempt from section 62L.03, subdivision 1, if the plan offers an annual open enrollment period of no less than 15 days during which all

employers that qualify for membership may enter the plan without preexisting condition limitations or exclusions except those permitted under chapter 62L.

~~(d)~~ (c) A joint self-insurance plan is exempt from sections 62A.146, 62A.16, 62A.17, 62A.20, 62A.21, and 62A.65, subdivision 5, paragraph (b), if the joint self-insurance plan complies with the continuation requirements under the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001, et seq., for all employers and not just for the employers with 20 or more employees who are covered by that federal law.

~~(e)~~ (d) A joint self-insurance plan must provide to all employers the maternity coverage required by federal law for employers with 15 or more employees.

~~(f)~~ (e) A joint self-insurance plan must comply with all the provisions and requirements of the Affordable Care Act as defined under section 62A.011, subdivision 1a, to the extent that they apply to such plans.

EFFECTIVE DATE; APPLICATION. This section is effective January 1, 2022, subject to certification under section 17, and applies to joint self-insurance plans operating under this section offered, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2018, section 62H.18, subdivision 9, is amended to read:

Subd. 9. **Compliance with other laws.** A joint self-insurance plan operating under this section:

~~(1) is exempt from providing the mandated health benefits in chapters 62A and 62Q, if the plan otherwise provides the benefits required under the Employee Retirement Income Security Act;~~

~~(2)~~ (1) is exempt from the continuation requirements in sections 62A.146, 62A.16, 62A.17, 62A.20, and 62A.21, if the plan complies with the continuation requirements under the Employee Retirement Income Security Act; and

~~(3)~~ (2) must comply with all requirements of the Affordable Care Act, as defined in section 62A.011, subdivision 1a, to the extent that they apply to such plans.

EFFECTIVE DATE; APPLICATION. This section is effective January 1, 2022, subject to certification under section 17, and applies to joint self-insurance plans operating under this section offered, issued, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2018, section 62U.04, subdivision 11, is amended to read:

Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's designee shall only use the data submitted under subdivisions 4 and 5 for the following purposes:

(1) to evaluate the performance of the health care home program as authorized under sections 256B.0751, subdivision 6, and 256B.0752, subdivision 2;

(2) to study, in collaboration with the reducing avoidable readmissions effectively (RARE) campaign, hospital readmission trends and rates;

(3) to analyze variations in health care costs, quality, utilization, and illness burden based on geographical areas or populations;

(4) to evaluate the state innovation model (SIM) testing grant received by the Departments of Health and Human Services, including the analysis of health care cost, quality, and utilization baseline and trend information for targeted populations and communities; and

(5) to compile one or more public use files of summary data or tables that must:

(i) be available to the public for no or minimal cost by March 1, 2016, and available by web-based electronic data download by June 30, 2019;

(ii) not identify individual patients, payers, or providers;

(iii) be updated by the commissioner, at least annually, with the most current data available;

(iv) contain clear and conspicuous explanations of the characteristics of the data, such as the dates of the data contained in the files, the absence of costs of care for uninsured patients or nonresidents, and other disclaimers that provide appropriate context; and

(v) not lead to the collection of additional data elements beyond what is authorized under this section as of June 30, 2015.

(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned.

(c) Nothing in this subdivision shall be construed to prohibit the commissioner from using the data collected under subdivision 4 to complete the state-based risk adjustment system assessment due to the legislature on October 1, 2015.

(d) The commissioner or the commissioner's designee may use the data submitted under subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1, 2023.

(e) The commissioner shall consult with the all-payer claims database work group established under subdivision 12 regarding the technical considerations necessary to create the public use files of summary data described in paragraph (a), clause (5).

(f) Notwithstanding subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner of human services or the commissioner's designee may use the data submitted under subdivisions 4 and 5 to set provider payment rates for the MinnesotaCare program under section 256L.11, subdivision 1a.

Sec. 4. Minnesota Statutes 2018, section 256L.03, subdivision 1, is amended to read:

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

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

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

(d) For the purposes of covered health services under this section, "child" means an individual younger than 19 years of age.

Sec. 5. Minnesota Statutes 2018, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) Families with children with family income above 133 percent of the federal poverty guidelines and equal to or less than ~~200 percent~~ the percentage of the federal poverty guidelines for the applicable family size specified in paragraph (b) shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18 shall apply unless otherwise specified. Children under age 19 with family income at or below 200 percent of the federal poverty guidelines

and who are ineligible for medical assistance by sole reason of the application of federal household composition rules for medical assistance are eligible for MinnesotaCare.

(b) Except as provided in paragraph (c), the income limit for determining MinnesotaCare eligibility under paragraph (a) and subdivision 7, is:

(1) 200 percent of the federal poverty guidelines through December 31, 2021;

(2) 300 percent of the federal poverty guidelines effective January 1, 2022;

(3) 400 percent of the federal poverty guidelines effective January 1, 2024; and

(4) 401 percent or more of the federal poverty guidelines effective January 1, 2025.

(c) Effective January 1, 2022, the MinnesotaCare income limit for persons in farm households is 400 percent of the federal poverty guidelines.

Sec. 6. Minnesota Statutes 2018, section 256L.04, subdivision 1c, is amended to read:

Subd. 1c. **General requirements.** To be eligible for MinnesotaCare, a person must meet the eligibility requirements of this section. A person eligible for MinnesotaCare with an income less than or equal to 200 percent of the federal poverty guidelines shall not be considered a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered through MNsure under chapter 62V.

Sec. 7. Minnesota Statutes 2018, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** The definition of eligible persons includes all individuals and families with no children who have incomes that are above 133 percent and equal to or less than 200 percent of the federal poverty guidelines for the applicable family size. The income limit for individuals and families with no children is increased as specified in subdivision 1, paragraph (b).

Sec. 8. Minnesota Statutes 2018, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above ~~200 percent~~ the percentage of the federal poverty guidelines specified in section 256L.04, subdivision 1, paragraph (b), are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month in which the commissioner sends advance notice according to Code of

Federal Regulations, title 42, section 431.211, that indicates the income of a family or individual exceeds program income limits.

Sec. 9. Minnesota Statutes 2018, section 256L.11, is amended by adding a subdivision to read:

Subd. 1a. **Enhanced Medicare payment rate.** (a) For purposes of this chapter, the "enhanced Medicare payment rate" for a service means 120 percent of the applicable Medicare payment rate.

(b) Payment to providers under this chapter shall be at the enhanced Medicare payment rate, unless:

(1) otherwise provided in this section;

(2) the commissioner, based upon an analysis of all payer claims data under section 62U.04, sets a different payment rate for specific services or provider types; or

(3) the commissioner negotiates a different payment rate with the provider.

Sec. 10. **[256L.122] SERVICE DELIVERY UNDER EXPANDED MINNESOTACARE PROGRAM.**

Subdivision 1. **Integrated health partnerships.** The commissioner shall contract with integrated health partnerships established under section 256B.0755 to provide covered services to MinnesotaCare enrollees beginning January 1, 2022, and, to the extent feasible, shall continue to apply the request for proposal process and payment, quality of care, and other contract terms developed under section 256B.0755 to integrated health partnerships serving MinnesotaCare enrollees.

Subd. 2. **Primary care case management.** Beginning January 1, 2022, the commissioner shall contract with eligible providers who are not part of an integrated health partnership to provide to MinnesotaCare enrollees covered services through the primary care case management program established under section 256L.123.

Subd. 3. **Enrollee selection of provider.** For coverage beginning on or after January 1, 2022, the commissioner shall require each MinnesotaCare enrollee to annually select a primary care clinic or provider organization to coordinate that enrollee's care. The commissioner may approve a specialty provider to coordinate the care of an enrollee with chronic or life-threatening health conditions. An enrollee may change the enrollee's primary care clinic or provider organization up to two times within a calendar year.

Subd. 4. **Termination of contracts.** The commissioner shall terminate managed care and county-based purchasing plan contracts under sections 256L.12 and 256L.121 effective January 1, 2022.

Sec. 11. **[256L.123] PRIMARY CARE CASE MANAGEMENT AND DIRECT CONTRACTING FOR MINNESOTACARE.**

Subdivision 1. **Program established.** The Primary Care Case Management (PCCM) program is established effective January 1, 2022, to achieve better health outcomes and reduce the cost of health care for the state.

Subd. 2. **Payment to providers.** (a) The commissioner of human services shall pay health care providers directly to provide services to MinnesotaCare enrollees who are not receiving services through an integrated health partnership.

(b) Providers shall bill the state directly for the services they provide.

Subd. 3. **Case management.** (a) In addition to paying providers under subdivision 2, the commissioner shall use the PCCM program to pay primary care providers under paragraph (c) for coordinating services for MinnesotaCare enrollees.

(b) Under the program, patients may choose a primary care provider to act as the enrollee's case manager. Primary care physicians, nurses, and other qualified medical professionals may provide primary care case management. Specialists who routinely provide care for patients with specific or complex medical conditions may also be primary care providers for purposes of case management.

(c) Primary care providers who offer PCCM services shall receive a flat per-member, per-month fee for performing care coordination services. The commissioner shall set case management fees to reflect the variation in time and services required for a primary care provider to coordinate care based on the complexity of a patient's health needs and socioeconomic factors that lead to health disparities.

(d) The primary care provider shall provide overall oversight of the enrollee's health and coordinate with any other case manager of the enrollee as well as ensure 24-hour access to health care, emergency treatment, and referrals.

(e) The commissioner shall collaborate with community health clinics and social service providers through planning and financing to provide outreach, medical care, and case management services in the community for patients who, because of mental illness, homelessness, or other circumstances, are unlikely to obtain needed care.

(f) The commissioner shall collaborate with medical and social service providers through planning and financing to reduce hospital readmissions by providing discharge planning and services, including medical respite and transitional care for patients leaving medical facilities and mental health and chemical dependency treatment programs.

Subd. 4. **Duties.** (a) For enrollees, the commissioner shall:

(1) maintain a hotline and website to assist enrollees in locating providers;

(2) provide a nurse consultation helpline 24 hours per day, seven days a week; and

(3) contact enrollees based on claims data who have not had preventive visits and help them select a primary care provider.

(b) For providers, the commissioner shall:

(1) review provider reimbursement rates to ensure reasonable and fair compensation;

(2) ensure that providers are reimbursed on a timely basis; and

(3) collaborate with providers to explore means of improving health care quality and reducing costs.

Sec. 12. Minnesota Statutes 2018, section 256L.15, subdivision 2, is amended to read:

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

(b) Beginning January 1, 2014, through December 31, 2021, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).

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

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

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

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

Federal Poverty Guideline Greater than or Equal to	**Less than**	**Individual Premium Amount**
35%	55%	$4

55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$14
120%	130%	$15
130%	140%	$16
140%	150%	$25
150%	160%	$37
160%	170%	$44
170%	180%	$52
180%	190%	$61
190%	200%	$71
200%		$80

(e) Effective January 1, 2022, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (f). The following persons are exempt from paying premiums under paragraph (f):

(1) persons 20 years of age or younger, with incomes not exceeding 200 percent of the federal poverty guidelines; and

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

Premiums under paragraph (f) are charged on a per-person basis, except that the total premium for households with three or more persons is limited to the total premium charge for a two-person household.

(f) Per-person premium scale for households, effective January 1, 2022:

Federal Poverty Guideline Percentage Greater than or Equal to	Federal Poverty Guideline Percentage Less than or Equal to	Per-Person Premium Amount
0	34	$0
35	54	$4
55	79	$6
80	89	$8
90	99	$10
100	109	$12
110	119	$14
120	129	$15

130	139	$16
140	149	$25
150	159	$37
160	169	$44
170	179	$52
180	189	$61
190	199	$71
200	200	$80
201	209	$91
210	219	$101
220	229	$111
230	239	$122
240	249	$134
250	259	$146
260	269	$157
270	279	$169
280	289	$181
290	299	$193
300	309	$206
310	319	$213
320	329	$220
330	339	$227
340	349	$234
350	359	$241
360	369	$248
370	379	$254
380	389	$261
390	399	$268
400		$275

For households with incomes greater than 400 percent of the federal poverty guidelines, the commissioner shall determine the per-person premium based on the highest required contribution percentage specified in the current required contribution table used for advance premium tax credits under United States Code, title 26, section 36B(b)(3)(A)(i), as indexed according to item (ii) of that section.

Sec. 13. Minnesota Statutes 2018, section 256L.15, is amended by adding a subdivision to read:

Subd. 5. **Employer contribution.** An employer with 150 or fewer employees may pay to the commissioner, as an employer contribution to employee health care costs, an amount up to the portion of an enrollee's MinnesotaCare premium for which the enrollee is financially responsible, for those employees who are enrolled in MinnesotaCare. An enrollee is eligible for MinnesotaCare under this subdivision without regard to any program income limit, but shall be financially responsible for premiums based on the sliding scale specified in section 256L.15, subdivision 2, paragraph (e).

Sec. 14. **[256L.30] MINNESOTACARE ADVISORY COUNCIL.**

Subdivision 1. **Establishment and duties.** (a) The commissioner of human services shall establish the MinnesotaCare Advisory Council to advise the commissioner on the transition to and ongoing administration of an expanded MinnesotaCare program.

(b) The council shall provide recommendations to the commissioner on:

(1) the health care services to be covered under the MinnesotaCare program, including community-based and institutional long-term care services;

(2) the development and administration of the MinnesotaCare sliding scale for premiums;

(3) provider payment methodologies;

(4) coordinating care delivery between the fee-for-service and integrated health partnership systems;

(5) ensuring adequate enrollee access to providers;

(6) measuring and improving the quality of care; and

(7) other issues the council determines are necessary to ensure the cost-effective delivery of high quality health care services through the MinnesotaCare program.

(c) If the commissioner does not adopt or implement a recommendation of the advisory council, the commissioner shall provide the advisory council with a written rationale for this decision.

Subd. 2. **Membership and governance.** (a) The council shall consist of the following 15 voting members and four nonvoting members, appointed by the commissioner unless otherwise provided:

(1) four members representing health care providers, of whom at least three must be currently practicing;

(2) one member representing employers;

(3) three members representing consumers, of whom one must represent persons with disabilities and at least one must represent underserved populations;

(4) three members with expertise in health care delivery, health economics, or health insurance;

(5) two members of the house of representatives, one from the majority party appointed by the speaker of the house and one from the minority party appointed by the minority leader;

(6) two members of the senate, one from the majority party appointed by the majority leader and one from the minority party appointed by the minority leader; and

(7) the commissioners of human services, health, commerce, and management and budget, or their designees, who shall be nonvoting members of the council.

(b) The commissioner of human services shall coordinate the commissioner's appointments to provide geographic, racial, and gender diversity.

(c) The council is governed by section 15.059, except that the non-consumer members of the council shall receive no compensation other than reimbursement for expenses. Notwithstanding section 15.059, subdivision 6, the council does not expire. The council is subject to chapter 13D.

(d) The commissioner shall provide staff and administrative services for the advisory council.

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

Sec. 15. **TRANSITION TO EXPANDED MINNESOTACARE PROGRAM.**

(a) The commissioner of human services shall continue to administer MinnesotaCare as a basic health program in accordance with Minnesota Statutes, section 256L.02, subdivision 5, and shall seek any federal waivers and approvals necessary to continue to receive federal basic health program payments or to receive other federal funding for the expanded MinnesotaCare program.

(b) The commissioner shall present an implementation plan for the expanded MinnesotaCare program to the chairs and ranking minority members of the legislative

committees with jurisdiction over health care policy and finance by December 15, 2020. The plan must include:

(1) recommendations for any changes to the expanded MinnesotaCare program necessary to continue federal basic health program funding or to receive other federal funding;

(2) a description of provider payment rates and methodologies;

(3) recommendations for coordinating care delivery between the primary care case management and integrated health partnership systems;

(4) recommendations for implementing Minnesota Statutes, section 256L.15, subdivision 5, in a manner that would allow any employee premium contributions to be pretax;

(5) recommendations for increasing MinnesotaCare provider enrollment, including an analysis of the feasibility of requiring participation in MinnesotaCare as a condition for state licensure;

(6) estimates of state costs related to the expansion; and

(7) draft legislation that includes any policy and conforming changes necessary to implement the MinnesotaCare expansion and implementation plan recommendations.

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

Sec. 16. **REPEALER.**

Subdivision 1. **Elimination of managed care.** Minnesota Statutes 2018, section 256L.12, is repealed.

Subd. 2. **Service delivery; competitive process.** Minnesota Statutes 2018, sections 256L.01, subdivision 7; and 256L.121, subdivisions 1 and 2, are repealed.

Subd. 3. **Payment rates.** Minnesota Statutes 2018, section 256L.11, subdivisions 1, 3, and 4, are repealed.

Subd. 4. **Must not have access to employer-subsidized minimum essential coverage.** Minnesota Statutes 2018, section 256L.07, subdivision 2, is repealed.

Sec. 17. **CONTINGENT EFFECTIVE DATE.**

Sections 1 to 13 and 16 are effective January 1, 2022, but only if the commissioner of human services certifies to the legislature that implementation of those sections will not result in the loss of federal basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of the federal poverty guidelines.

256L.01 DEFINITIONS.

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

256L.07 ELIGIBILITY FOR MINNESOTACARE.

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

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

256L.11 PROVIDER PAYMENT.

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

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

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

256L.12 MANAGED CARE.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions, when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must

include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

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

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

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

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

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

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

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospitals admission rate compared to the hospital admission rate for calendar year 2011 as determined by the commissioner. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance

target is achieved. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (f).

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

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

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

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

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

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

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

Subd. 11. **Coverage at Indian health service facilities.** For American Indian enrollees of MinnesotaCare, MinnesotaCare shall cover health care services provided at Indian health service facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Act, Public Law 93-638, if those services would otherwise be covered under section 256L.03. Payments for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or organization, be made at the rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34, for those MinnesotaCare enrollees eligible for coverage at medical assistance rates. For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in Code of Federal Regulations, title 42, section 36.12.

256L.121 SERVICE DELIVERY.

Subdivision 1. **Competitive process.** The commissioner of human services shall establish a competitive process for entering into contracts with participating entities for the offering of standard health plans through MinnesotaCare. Coverage through standard health plans must be available to enrollees beginning January 1, 2015. Each standard health plan must cover the health services listed in and meet the requirements of section 256L.03. The competitive process must meet the requirements of section 1331 of the Affordable Care Act and be designed to ensure enrollee access to high-quality health care coverage options. The commissioner, to the extent feasible, shall seek to ensure that enrollees have a choice of coverage from more than one participating entity within a geographic

area. In counties that were part of a county-based purchasing plan on January 1, 2013, the commissioner shall use the medical assistance competitive procurement process under section 256B.69, under which selection of entities is based on criteria related to provider network access, coordination of health care with other local services, alignment with local public health goals, and other factors.

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

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

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