SENATE
STATE OF MINNESOTA
EIGHTY-EIGHTH LEGISLATURE

S.F. No. 184

(SENATE AUTHORS: LOUREY, Hayden, Sheran, Dibble and Franzen)

DATE	D-PG	OFFICIAL STATUS
01/31/2013	127	Introduction and first reading Referred to Health, Human Services and Housing
03/18/2013	1061a	Comm report: To pass as amended and re-refer to Finance See HF1233, Art. 1, Sec. 1, 3, 27-28, 32-35, 38-41, 43, 49-50, 52, 54, 58, 61

A bill for an act

relating to human services; establishing MinnesotaCare as the state's basic health program; amending Minnesota Statutes 2012, sections 16A.724, subdivision 3; 256.01, by adding a subdivision; 256B.0625, subdivision 3a; 256B.0755, subdivision 3; 256B.694; 256L.01, by adding subdivisions; 256L.02, subdivision 2, by adding subdivisions; 256L.03, subdivisions 1, 3, 5, 6, by adding subdivisions; 256L.04, by adding subdivisions; 256L.05, subdivisions 1, 2, 3, 3a, 3c, by adding a subdivision; 256L.07, subdivision 1; 256L.09, subdivision 2; 256L.11, subdivision 1, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 256L; repealing Minnesota Statutes 2012, sections 256L.01, subdivisions 3, 3a, 4a, 5; 256L.02, subdivision 3; 256L.03, subdivisions 1a, 3, 4, 5; 256L.031; 256L.04, subdivisions 1, 1b, 2a, 7, 7a, 8, 9, 13; 256L.05, subdivisions 1b, 1c, 5; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3, 4, 5, 8, 9; 256L.09, subdivisions 1, 4, 5, 6, 7; 256L.11, subdivisions 2a, 3, 6; 256L.12; 256L.15, subdivisions 1, 1a, 1b, 2; 256L.17, subdivisions 1, 2, 3, 4, 5.

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

Section 1. Minnesota Statutes 2012, section 16A.724, subdivision 3, is amended to read:

Subd. 3. **MinnesotaCare federal receipts.** ~~Receipts received as a result of federal participation pertaining to administrative costs of the Minnesota health care reform waiver shall be deposited as nondedicated revenue in the health care access fund. Receipts received as a result of federal participation pertaining to grants shall be deposited in the federal fund and shall offset health care access funds for payments to providers.~~ All federal funding received by Minnesota for implementation and administration of MinnesotaCare as a basic health program, as authorized in section 1331 of the Affordable Care Act (Public Law 111-148, as amended by Public Law 111-152), is dedicated to that program and shall be deposited into the health care access fund. Federal funding that is received for implementing and administering MinnesotaCare as a basic health program and deposited in

the fund shall be used only for that program to purchase health care coverage for enrollees and reduce enrollee premiums and cost-sharing or provide additional enrollee benefits.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 2. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision to read:

Subd. 35. **Federal approval.** (a) The commissioner shall seek federal authority from the U.S. Department of Health and Human Services necessary to operate a health insurance program for Minnesotans with incomes up to 275 percent of the federal poverty guidelines (FPG). The proposal shall seek to secure all federal funding available from at least the following services:

(1) all premium tax credits and cost sharing subsidies available under United States Code, title 26, section 36B, and United States Code, title 42, section 18071, for individuals with incomes above 133 percent and at or below 275 percent of the federal poverty guidelines who would otherwise be enrolled in the Minnesota Insurance Marketplace as defined in section 62V.02, if enacted in 2013 H.F. No. 5/S.F. No. 1;

(2) Medicaid funding; and

(3) other funding sources identified by the commissioner that support coverage or care redesign in Minnesota.

(b) Funding received shall be used to design and implement a health insurance program that creates a single streamlined program and meets the needs of Minnesotans with incomes up to 275 percent of the federal poverty guidelines. The program must incorporate:

(1) payment reform characteristics included in the health care delivery system and accountable care organization payment models;

(2) flexibility in benefit set design such that benefits can be targeted to meet enrollee needs in different income and health status situations and can provide a more seamless transition from public to private health care coverage;

(3) flexibility in co-payment or premium structures to incent patients to seek high quality, low cost care settings; and

(4) flexibility in premium structures to ease the transition from public to private health care coverage.

(c) The commissioner shall develop and submit a proposal consistent with the above criteria and shall seek all federal authority necessary to implement the coverage program. In developing the request, the commissioner shall consult with appropriate stakeholder groups and consumers.

(d) The commissioner is authorized to seek any available waivers or federal approvals to accomplish the goals under paragraph (b) prior to 2017.

(e) The commissioner shall report progress on implementing this section to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and financing by December 1, 2014.

(f) The commissioner is authorized to accept and expend federal funds that support the purposes of this section.

Sec. 3. Minnesota Statutes 2012, section 256B.0625, subdivision 3a, is amended to read:

Subd. 3a. **Sex reassignment surgery.** Sex reassignment surgery is not covered, unless medically necessary.

Sec. 4. Minnesota Statutes 2012, section 256B.0755, subdivision 3, is amended to read:

Subd. 3. **Accountability.** (a) Health care delivery systems must accept responsibility for the quality of care based on standards established under subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services provided to its enrollees under subdivision 1, paragraph (b), clause (1).

(b) A health care delivery system may contract and coordinate with providers and clinics for the delivery of services and shall contract with community health clinics, federally qualified health centers, community mental health centers or programs, county agencies, and rural clinics to the extent practicable.

(c) A health care delivery system must demonstrate how its services will be coordinated with other services affecting its attributed patients' health, quality of care, and cost of care that are provided by other providers and county agencies in the local service. The health care delivery system must document how other providers and counties, including county-based purchasing plans, will provide services to persons attributed to the health care delivery system participated in developing the application. A health care delivery system must document how it will address applicable local needs, priorities, and public health goals.

Sec. 5. Minnesota Statutes 2012, section 256B.694, is amended to read:

256B.694 SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE CONTRACT.

(a) MS 2010 [Expired, 2008 c 364 s 10]

(b) The commissioner shall consider, and may approve, contracting on a single-health plan basis with ~~other~~ county-based purchasing plans, or with other qualified

health plans that have coordination arrangements with counties, to serve persons ~~with a disability who voluntarily enroll~~ enrolled in state health care programs, in order to promote better coordination or integration of health care services, social services and other community-based services, provided that all requirements applicable to health plan purchasing, including those in section 256B.69, subdivision 23, are satisfied. ~~Nothing in this paragraph supersedes or modifies the requirements in paragraph (a).~~

Sec. 6. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision to read:

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

Sec. 7. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision to read:

Subd. 4b. **Minnesota Insurance Marketplace.** "Minnesota Insurance Marketplace" means the Minnesota Insurance Marketplace as defined in section 62V.02, if enacted in 2013 H.F. No. 5/S.F. No. 1.

Sec. 8. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision to read:

Subd. 6. **MinnesotaCare.** "MinnesotaCare" means a health coverage program that meets the standards of this chapter and the requirements for a basic health program under section 1331 of the Affordable Care Act.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 9. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision to read:

Subd. 7. **Modified adjusted gross income and household income.** "Modified adjusted gross income" and "household income" have the meanings provided in section 2002 of the Affordable Care Act.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 10. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision to read:

Subd. 8. **Participating entity.** "Participating entity" means a health plan company as defined in section 62Q.01, subdivision 4; 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.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 11. Minnesota Statutes 2012, section 256L.02, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide covered health services for eligible persons. Payment for these services shall be made to all ~~eligible providers~~ participating entities under contract with the commissioner. The commissioner shall adopt rules to administer the MinnesotaCare program as a basic health program in accordance with section 1331 of the Affordable Care Act and this chapter and shall adopt any necessary rules. Nothing in this chapter is intended to violate the requirements of the Affordable Care Act. The commissioner shall not implement any provision of this chapter if the provision is found to violate the Affordable Care Act. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the Department of Human Services. A toll-free telephone number must be used to provide information about medical programs and to promote access to the covered services.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 12. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision to read:

Subd. 5. **Determination of funding adequacy.** The commissioners of revenue and Minnesota Management and Budget, in consultation with the commissioner of human services, shall conduct an assessment of health care taxes, including the gross premiums tax, the provider tax, and Medicaid surcharges, and their relationship to the long-term solvency of the health care access fund, as part of the state revenue and expenditure forecast in November 2013. The commissioners shall determine the amount of state funding that will be required after December 31, 2019, in addition to the federal payments made available under section 1331 of the Affordable Care Act, for the MinnesotaCare

program. The commissioners shall evaluate the stability and likelihood of long-term federal funding for the MinnesotaCare program under section 1331. The commissioners shall report the results of this assessment to the legislature by January 15, 2014, along with recommendations for changes to state revenue for the health care access fund, if state funding will continue to be required beyond December 31, 2019.

Sec. 13. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision to read:

Subd. 6. **Federal approval.** (a) The commissioner of human services shall seek federal approval to implement the MinnesotaCare program under this chapter as a basic health program. In any agreement with the Centers for Medicare and Medicaid Services to operate MinnesotaCare as a basic health program, the commissioner shall seek to include procedures to ensure that federal funding is predictable, stable, and sufficient to sustain ongoing operation of MinnesotaCare. These procedures must address issues related to the timing of federal payments, payment reconciliation, enrollee risk adjustment, and minimization of state financial risk. The commissioner shall consult with the commissioner of Minnesota Management and Budget, when developing the proposal for establishing MinnesotaCare as a basic health program to be submitted to the Centers for Medicare and Medicaid Services.

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

(c) The commissioner of human services, through December 31, 2015, may modify the MinnesotaCare program as specified in this chapter, if it is necessary to enhance health benefits, expand provider access, or reduce cost-sharing and premiums in order to comply with the terms and conditions of federal approval as a basic health program. The commissioner may not reduce benefits, impose greater limits on access to providers, or increase cost-sharing and premiums by enrollees under the authority granted by this paragraph. If the commissioner modifies the terms and requirements for MinnesotaCare under this paragraph, the commissioner shall provide the legislature with notice of implementation of the modifications at least ten working days before notifying enrollees

and participating entities. The costs of any changes to the program necessary to comply with federal approval shall become part of the program's base funding for purposes of future budget forecasts.

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

Sec. 14. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision to read:

Subd. 7. **Coordination with Minnesota Insurance Marketplace.** MinnesotaCare shall be considered a MAGI public health care program for purposes of chapter 62V if enacted in 2013 H.F. No. 5/S.F. No. 1.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 15. Minnesota Statutes 2012, 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, and all essential health benefits required under section 1302 of the Affordable Care Act, with the exception of ~~inpatient hospital services, special education services, private duty 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, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services~~ nursing facility services and intermediate care facility for persons with developmental disabilities (ICF/DD) services, and except as provided in this section.

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

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

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 16. Minnesota Statutes 2012, section 256L.03, subdivision 3, is amended to read:

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

assistance spenddown. ~~The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant, is subject to an annual limit of $10,000.~~

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

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

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

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 17. Minnesota Statutes 2012, section 256L.03, is amended by adding a subdivision to read:

Subd. 4a. **Cost-sharing.** (a) Except as provided in paragraph (b), the MinnesotaCare program shall include the following cost-sharing requirements for all enrollees:

(1) $3 per brand-name prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for treatment of mental illness;

(2) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist; and

(3) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval.

(b) Paragraph (a), clause (2), does not apply to mental health services.

(c) The commissioner, through the contracting process under section 256L.121, may allow participating entities to waive the family deductible described under paragraph (a), clause (4). The value of the family deductible shall not be included in any capitation or other payment made by the commissioner to participating entities. Participating entities shall certify annually to the commissioner the dollar value of the family deductible.

(d) The commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 18. Minnesota Statutes 2012, section 256L.03, is amended by adding a subdivision to read:

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

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 19. Minnesota Statutes 2012, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Except as provided in ~~paragraphs~~ paragraph (b) ~~and (c)~~, the MinnesotaCare benefit plan shall include the following cost-sharing requirements for all enrollees:

~~(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual;~~

~~(2)~~ (1) $3 per prescription for adult enrollees;

~~(3)~~ (2) $25 for eyeglasses for adult enrollees;

~~(4)~~ (3) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

~~(5)~~ (4) $6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and $3.50 effective January 1, 2011; and

~~(6)~~ (5) a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54.

~~(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21.~~

~~(c)~~ (b) Paragraph (a) does not apply to pregnant women and children under the age of 21.

~~(d)~~ (c) Paragraph (a), clause ~~(4)~~ (3), does not apply to mental health services.

~~(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the $10,000 inpatient hospital benefit limit.~~

~~(f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the $10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.~~

~~(g)~~ (d) MinnesotaCare reimbursements to fee-for-service providers and payments to managed care plans or county-based purchasing plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause ~~(5)~~ (4), effective January 1, 2011.

~~(h)~~ (e) The commissioner, through the contracting process under section 256L.12, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause ~~(6)~~ (5). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 20. Minnesota Statutes 2012, section 256L.03, subdivision 6, is amended to read:

Subd. 6. **Lien.** When the state agency provides, pays for, or becomes liable for covered health services, the agency shall have a lien for the cost of the covered health services upon any and all causes of action accruing to the enrollee, or to the enrollee's legal representatives, as a result of the occurrence that necessitated the payment for the covered health services. All liens under this section shall be subject to the provisions of section 256.015. For purposes of this subdivision, "state agency" includes ~~prepaid health plans~~ participating entities, under contract with the commissioner according to ~~sections 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; and county-based purchasing entities under section 256B.692~~ section 256L.121.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 21. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision to read:

Subd. 1c. **General requirements.** To be eligible for coverage under MinnesotaCare, a person must meet the eligibility requirements of this section. A person eligible for MinnesotaCare shall not be treated as a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered through the health benefit exchange under section 1331 of the Affordable Care Act.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 22. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision to read:

Subd. 1d. **Eligible groups; income limits.** (a) To be eligible under MinnesotaCare, a person must:

(1) be a resident of Minnesota;

(2) not be eligible under medical assistance;

(3) have a household income that is greater than 133 percent but does not exceed 200 percent of the federal poverty guidelines for family size, except that a noncitizen lawfully present in the United States, who is not eligible for the Medicaid program under title XIX of the Social Security Act due to immigration status, may have a household income that is less than or equal to 133 percent of the federal poverty guidelines for family size;

(4) not be eligible for minimum essential coverage, as defined in section 5000A(f) of the Internal Revenue Code of 1986, except that a person may be eligible for an employer-sponsored plan that is not affordable coverage, as defined in section 5000A(e)(2) of the Internal Revenue Code of 1986; and

(5) not have attained the age of 65 as of the beginning of the plan year.

(b) The commissioner shall calculate income eligibility under MinnesotaCare using modified adjusted gross income and shall apply a standard five percent income disregard, as provided under section 2012 of the Affordable Care Act.

EFFECTIVE DATE. Paragraph (a) of this section is effective January 1, 2015. Paragraph (b) of this section is effective January 1, 2014.

Sec. 23. Minnesota Statutes 2012, section 256L.05, subdivision 1, is amended to read:

Subdivision 1. **Application assistance and information availability.** (a) Applicants may submit applications online, in person, by mail, or by phone in accordance with the Affordable Care Act, and by any other means by which medical assistance applications may be submitted. Applicants may submit applications through the Minnesota Insurance Marketplace or through the MinnesotaCare program. Applications and application

assistance must be made available at provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches, community health offices, Women, Infants and Children (WIC) program sites, Head Start program sites, public housing councils, crisis nurseries, child care centers, early childhood education and preschool program sites, legal aid offices, and libraries, and at any other locations at which medical assistance applications must be made available. These sites may accept applications and forward the forms to the commissioner or local county human services agencies that choose to participate as an enrollment site. Otherwise, applicants may apply directly to the commissioner or to participating local county human services agencies.

(b) Application assistance must be available for applicants choosing to file an online application through the Minnesota Insurance Marketplace.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 24. Minnesota Statutes 2012, section 256L.05, is amended by adding a subdivision to read:

Subd. 1d. **Streamlined application and enrollment process.** The commissioner shall work with the board of the Minnesota Insurance Marketplace and local human services agencies to develop a single, streamlined application and automatic enrollment process that meets the requirements of the Affordable Care Act, including but not limited to being structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for MinnesotaCare and medical assistance. Each application shall give an applicant the option, to the extent feasible, of specifying their current primary care clinic or physician as their primary care provider for purposes of continuity of care.

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

Sec. 25. Minnesota Statutes 2012, section 256L.05, subdivision 2, is amended to read:

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

and any other governmental agency in order to perform income verification related to eligibility ~~and premium payment under the MinnesotaCare program~~.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 26. Minnesota Statutes 2012, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved ~~and the first premium payment has been received. As provided in section 256B.057, coverage for newborns is automatic from the date of birth and must be coordinated with other health coverage. The effective date of coverage for eligible newly adoptive children added to a family receiving covered health services is the month of placement. The effective date of coverage for other new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's gross income and the adjusted premium begins in the month the new family member is added~~.

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

~~(c) Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage.~~

~~(d)~~ (b) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

~~(e) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, subdivision 1, paragraph (d), is the first day of the month following the month in which verification of American Indian status is received or eligibility is approved, whichever is later.~~

~~(f)~~ (c) The effective date of coverage for children eligible under section 256L.07, subdivision 8, is the first day of the month following the date of termination from foster care or release from a juvenile residential correctional facility.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 27. Minnesota Statutes 2012, 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. ~~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 children enrolled in MinnesotaCare under section 256L.07, subdivision 8, the first period of renewal begins the month the enrollee turns 21 years of age.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 28. Minnesota Statutes 2012, section 256L.05, subdivision 3c, is amended to read:

Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective date of coverage shall be the first day of the month following termination from medical assistance for families and individuals who are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance. The applicant must provide all required verifications within 30 days of the written request for verification. ~~For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing. General assistance medical care recipients may qualify for retroactive coverage under this subdivision at six-month renewal.~~

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 29. Minnesota Statutes 2012, 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 200 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.~~

Parents enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 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 250 percent of the federal poverty guidelines on or after July 1, 2009, 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) Children may remain enrolled in MinnesotaCare if their gross family income as defined in section 256L.01, subdivision 4, is greater than 275 percent of federal poverty guidelines. The premium for children remaining eligible under this paragraph shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(c) Notwithstanding paragraph (a), parents are not eligible for MinnesotaCare if gross household income exceeds $57,500 for the 12-month period of eligibility.

EFFECTIVE DATE. This section is effective January 1, 2014.

Sec. 30. Minnesota Statutes 2012, section 256L.09, subdivision 2, is amended to read:

Subd. 2. **Residency requirement.** To be eligible for health coverage under the MinnesotaCare program, ~~pregnant women, individuals, and families with children must meet the residency requirements~~ individuals must be a resident of the state as provided by ~~Code of Federal Regulations, title 42, section 435.403, except that the provisions of section 256B.056, subdivision 1, shall apply upon receipt of federal approval~~ section 1331 of the Affordable Care Act.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 31. Minnesota Statutes 2012, section 256L.11, subdivision 1, is amended to read:

Subdivision 1. **Medical assistance rate to be used.** ~~(a)~~ Payment to providers under ~~sections 256L.01 to 256L.11~~ this chapter shall be at the same rates and conditions established for medical assistance, except as provided in ~~subdivisions 2 to 6~~ this section.

~~(b) Effective for services provided on or after July 1, 2009, total payments for basic care services shall be reduced by three percent, in accordance with section 256B.766. Payments made to managed care and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.~~

~~(c) Effective for services provided on or after July 1, 2009, payment rates for physician and professional services shall be reduced as described under section 256B.76, subdivision 1, paragraph (c). Payments made to managed care and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.~~

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 32. Minnesota Statutes 2012, section 256L.11, is amended by adding a subdivision to read:

Subd. 1a. **Rate increases.** Effective for services provided on or after January 1, 2015, the commissioner of human services shall increase payments for basic care services, physician and professional services, and dental services by … percent from the rates in effect for the MinnesotaCare program on December 31, 2014. Payments to participating entities established through the competitive process under section 256L.121 must reflect this increase.

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 33. **[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.

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

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

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

Subd. 3. **Coordination with state-administered health programs.** The commissioner shall coordinate the administration of the MinnesotaCare program with

medical assistance to maximize efficiency and improve the continuity of care. This includes, but is not limited to:

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

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

(3) providing MinnesotaCare enrollees, to the extent possible, with the option to remain in the same health plan and provider network, if they later become eligible for medical assistance or coverage through the Minnesota health benefit exchange; and

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

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

Sec. 34. **PLAN FOR CONSOLIDATION OF PUBLIC PROGRAMS.**

The commissioner of human services shall develop and present to the legislature by January 15, 2014, a plan for a consolidated and streamlined state health care program that combines the current medical assistance and MinnesotaCare programs, uses a standard and simplified application process through the Minnesota Insurance Marketplace, and provides seamless delivery and coordination of care between state health care programs and health coverage available through the Minnesota Insurance Marketplace.

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

Sec. 35. **REVISOR'S INSTRUCTION.**

The revisor shall remove cross-references to the sections repealed in this act wherever they appear in Minnesota Statutes and Minnesota Rules and make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

Sec. 36. **REPEALER.**

(a) Minnesota Statutes 2012, sections 256L.01, subdivisions 4a and 5; 256L.031; and 256L.07, subdivisions 2 and 3, are repealed, effective July 1, 2014.

(b) Minnesota Statutes 2012, sections 256L.01, subdivisions 3 and 3a; 256L.02, subdivision 3; 256L.03, subdivisions 1a, 3, 4, and 5; 256L.04, subdivisions 1, 1b, 2a, 7, 7a, 8, 9, and 13; 256L.05, subdivisions 1b, 1c, and 5; 256L.06, subdivision 3; 256L.07, subdivisions 1, 4, 5, 8, and 9; 256L.09, subdivisions 1, 4, 5, 6, and 7; 256L.11, subdivisions 2a, 3, and 6; 256L.12; 256L.15, subdivisions 1, 1a, 1b, and 2; and 256L.17, subdivisions 1, 2, 3, 4, and 5, are repealed effective January 1, 2015.

256L.01 DEFINITIONS.

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

Subd. 3a. **Family with children.** (a) "Family with children" means:

(1) parents and their children residing in the same household; or

(2) grandparents, foster parents, relative caretakers as defined in the medical assistance program, or legal guardians; and their wards who are children residing in the same household.

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

Subd. 4a. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the 12-month period of eligibility using as a baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in depreciation, and carryover net operating loss amounts that apply to the business in which the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the 12-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year.

(c) "Gross individual or gross family income" means the total income for all family members, calculated for the 12-month period of eligibility.

Subd. 5. **Income.** (a) "Income" has the meaning given for earned and unearned income for families and children in the medical assistance program, according to the state's aid to families with dependent children plan in effect as of July 16, 1996. The definition does not include medical assistance income methodologies and deeming requirements. The earned income of full-time and part-time students under age 19 is not counted as income. Public assistance payments and supplemental security income are not excluded income.

(b) For purposes of this subdivision, and unless otherwise specified in this section, the commissioner shall use reasonable methods to calculate gross earned and unearned income including, but not limited to, projecting income based on income received within the past 30 days, the last 90 days, or the last 12 months.

256L.02 PROGRAM ADMINISTRATION.

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

256L.03 COVERED HEALTH SERVICES.

Subd. 1a. **Pregnant women and children; MinnesotaCare health care reform waiver.** Beginning January 1, 1999, children and pregnant women are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program according to chapter 256B, except that abortion services under MinnesotaCare shall be limited as provided under subdivision 1. Pregnant women and children are exempt from the provisions of subdivision 5, regarding co-payments. Pregnant women and children who are lawfully residing in the United States but who are not "qualified noncitizens" under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all services provided under the medical assistance program according to chapter 256B.

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown. The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant, is subject to an annual limit of $10,000.

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

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

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

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

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

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual;

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(5) $6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and $3.50 effective January 1, 2011; and

(6) a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21.

(c) Paragraph (a) does not apply to pregnant women and children under the age of 21.

(d) Paragraph (a), clause (4), does not apply to mental health services.

(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the $10,000 inpatient hospital benefit limit.

(f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the $10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

(g) MinnesotaCare reimbursements to fee-for-service providers and payments to managed care plans or county-based purchasing plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause (5), effective January 1, 2011.

(h) The commissioner, through the contracting process under section 256L.12, may allow managed care plans and county-based purchasing plans to waive the family deductible

under paragraph (a), clause (6). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

256L.031 HEALTHY MINNESOTA CONTRIBUTION PROGRAM.

Subdivision 1. **Defined contributions to enrollees.** (a) Beginning July 1, 2012, the commissioner shall provide each MinnesotaCare enrollee eligible under section 256L.04, subdivision 7, with family income equal to or greater than 200 percent of the federal poverty guidelines with a monthly defined contribution to purchase health coverage under a health plan as defined in section 62A.011, subdivision 3.

(b) Enrollees eligible under this section shall not be charged premiums under section 256L.15 and are exempt from the managed care enrollment requirement of section 256L.12.

(c) Sections 256L.03; 256L.05, subdivision 3; and 256L.11 do not apply to enrollees eligible under this section unless otherwise provided in this section. Covered services, cost sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage for enrollees eligible under this section shall be as provided under the terms of the health plan purchased by the enrollee.

(d) Unless otherwise provided in this section, all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration, continue to apply to enrollees obtaining coverage under this section.

Subd. 2. **Use of defined contribution; health plan requirements.** (a) An enrollee may use up to the monthly defined contribution to pay premiums for coverage under a health plan as defined in section 62A.011, subdivision 3, or as provided in section 256L.031, subdivision 6.

(b) An enrollee must select a health plan within four calendar months of approval of MinnesotaCare eligibility. If a health plan is not selected and purchased within this time period, the enrollee must reapply and must meet all eligibility criteria. The commissioner may determine criteria under which an enrollee has more than four calendar months to select a health plan.

(c) Coverage purchased under this section must:

(1) include mental health and chemical dependency treatment services; and

(2) comply with the coverage limitations specified in section 256L.03, subdivision 1, paragraph (b).

Subd. 3. **Determination of defined contribution amount.** (a) The commissioner shall determine the defined contribution sliding scale using the base contribution specified in this paragraph for the specified age ranges. The commissioner shall use a sliding scale for defined contributions that provides:

(1) persons with household incomes equal to 200 percent of the federal poverty guidelines with a defined contribution of 93 percent of the base contribution;

(2) persons with household incomes equal to 250 percent of the federal poverty guidelines with a defined contribution of 80 percent of the base contribution; and

(3) persons with household incomes in evenly spaced increments between the percentages of the federal poverty guideline or income level specified in clauses (1) and (2) with a base contribution that is a percentage interpolated from the defined contribution percentages specified in clauses (1) and (2).

19-29	$125
30-34	$135
35-39	$140
40-44	$175
45-49	$215
50-54	$295
55-59	$345
60+	$360

(b) The commissioner shall multiply the defined contribution amounts developed under paragraph (a) by 1.20 for enrollees who purchase coverage through the Minnesota Comprehensive Health Association.

Subd. 4. **Administration by commissioner.** (a) The commissioner shall administer the defined contributions. The commissioner shall:

(1) calculate and process defined contributions for enrollees; and

(2) pay the defined contribution amount to health plan companies or the Minnesota Comprehensive Health Association, as applicable, for enrollee health plan coverage.

(b) Nonpayment of a health plan premium shall result in disenrollment from MinnesotaCare effective 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 may not reenroll until four calendar months have elapsed.

Subd. 5. **Assistance to enrollees.** The commissioner of human services, in consultation with the commissioner of commerce, shall develop an efficient and cost-effective method of referring eligible applicants to professional insurance agent associations.

Subd. 6. **Minnesota Comprehensive Health Association (MCHA).** Beginning July 1, 2012, MinnesotaCare enrollees eligible for coverage through a health plan offered by the Minnesota Comprehensive Health Association may enroll in MCHA in accordance with section 62E.14. Any difference between the revenue and actual covered losses to MCHA related to the implementation of this section are appropriated annually to the commissioner of human services from the health care access fund and shall be paid to MCHA.

Subd. 7. **Federal approval.** The commissioner shall seek federal financial participation for the adult enrollees eligible under this section.

256L.04 ELIGIBLE PERSONS.

Subdivision 1. **Families with children.** (a) Families with children with family income equal to or less than 275 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) Parents are not eligible for MinnesotaCare if their gross income exceeds $57,500.

(e) Children deemed eligible for MinnesotaCare under section 256L.07, subdivision 8, are exempt from the eligibility requirements of this subdivision.

Subd. 1b. **Children with family income greater than 275 percent of federal poverty guidelines.** Children with family income greater than 275 percent of federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare. 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.

Subd. 2a. **Applications for other benefits.** To be eligible for MinnesotaCare, individuals and families must take all necessary steps to obtain other benefits as described in Code of Federal Regulations, title 42, section 435.608. Applicants and enrollees must apply for other benefits within 30 days of notification.

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 250 percent of the federal poverty guidelines.

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

Subd. 8. **Applicants potentially eligible for medical assistance.** (a) Individuals who receive supplemental security income or retirement, survivors, or disability benefits due to a disability, or other disability-based pension, who qualify under subdivision 7, but who are potentially eligible for medical assistance without a spenddown shall be allowed to enroll in MinnesotaCare for a period of 60 days, so long as the applicant meets all other conditions of eligibility. The commissioner shall identify and refer the applications of such individuals to their

county social service agency. The county and the commissioner shall cooperate to ensure that the individuals obtain medical assistance coverage for any months for which they are eligible.

(b) The enrollee must cooperate with the county social service agency in determining medical assistance eligibility within the 60-day enrollment period. Enrollees who do not cooperate with medical assistance within the 60-day enrollment period shall be disenrolled from the plan within one calendar month. Persons disenrolled for nonapplication for medical assistance may not reenroll until they have obtained a medical assistance eligibility determination. Persons disenrolled for noncooperation with medical assistance may not reenroll until they have cooperated with the county agency and have obtained a medical assistance eligibility determination.

(c) Beginning January 1, 2000, counties that choose to become MinnesotaCare enrollment sites shall consider MinnesotaCare applications to also be applications for medical assistance. Applicants who are potentially eligible for medical assistance, except for those described in paragraph (a), may choose to enroll in either MinnesotaCare or medical assistance.

(d) The commissioner shall redetermine provider payments made under MinnesotaCare to the appropriate medical assistance payments for those enrollees who subsequently become eligible for medical assistance.

Subd. 9. **General assistance medical care.** A person cannot have coverage under both MinnesotaCare and general assistance medical care in the same month. Eligibility for MinnesotaCare cannot be replaced by eligibility for general assistance medical care, and eligibility for general assistance medical care cannot be replaced by eligibility for MinnesotaCare.

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

256L.05 APPLICATION PROCEDURES.

Subd. 1b. **MinnesotaCare enrollment by county agencies.** Beginning September 1, 2006, county agencies shall enroll single adults and households with no children formerly enrolled in general assistance medical care in MinnesotaCare according to Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3. County agencies shall perform all duties necessary to administer the MinnesotaCare program ongoing for these enrollees, including the redetermination of MinnesotaCare eligibility at renewal.

Subd. 1c. **Open enrollment and streamlined application and enrollment process.**

Subd. 5. **Availability of private insurance.** The commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage and the possibility of disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c), to all: (1) families enrolled in the MinnesotaCare program whose gross family income is equal to or more than 225 percent of the federal poverty guidelines; and (2) single adults and households without children enrolled in the MinnesotaCare program whose gross family income is equal to or more than 165 percent of the federal poverty guidelines. This information must be provided upon initial enrollment and annually thereafter. The commissioner shall also include information regarding the availability of private health insurance coverage in the notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c).

256L.06 PREMIUM ADMINISTRATION.

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

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

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

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month 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. 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.

256L.07 ELIGIBILITY FOR MINNESOTACARE.

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 200 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.

Parents enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 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 250 percent of the federal poverty guidelines on or after July 1, 2009, 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) Children may remain enrolled in MinnesotaCare if their gross family income as defined in section 256L.01, subdivision 4, is greater than 275 percent of federal poverty guidelines. The premium for children remaining eligible under this paragraph shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(c) Notwithstanding paragraph (a), parents are not eligible for MinnesotaCare if gross household income exceeds $57,500 for the 12-month period of eligibility.

Subd. 2. **Must not have access to employer-subsidized coverage.** (a) To be eligible, a family or individual must not have access to subsidized health coverage through an employer and must not have had access to employer-subsidized coverage through a current employer for 18 months prior to application or reapplication. A family or individual whose employer-subsidized coverage is lost due to an employer terminating health care coverage as an employee benefit during the previous 18 months is not eligible.

(b) This subdivision does not apply to a family or individual who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit. This subdivision does not apply to children with family gross incomes that are equal to or less than 200 percent of federal poverty guidelines.

(c) For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee or dependent, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans and any other employer benefits intended to pay health care costs as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.

Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled. Children with family gross incomes equal to or greater than 200 percent of federal poverty guidelines, and adults, must have had no health

coverage 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 200 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) Coverage purchased as provided under section 256L.031, subdivision 2, medical assistance, 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) Applicants who were recipients of medical assistance 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.

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

Subd. 5. **Voluntary disenrollment for members of military.** Notwithstanding section 256L.05, subdivision 3b, MinnesotaCare enrollees who are members of the military and their families, who choose to voluntarily disenroll from the program when one or more family members are called to active duty, may reenroll during or following that member's tour of active duty. Those individuals and families shall be considered to have good cause for voluntary termination under section 256L.06, subdivision 3, paragraph (d). Income and asset increases reported at the time of reenrollment shall be disregarded. All provisions of sections 256L.01 to 256L.18 shall apply to individuals and families enrolled under this subdivision upon 12-month renewal.

Subd. 8. **Automatic eligibility for certain children.** Any child who was residing in foster care or a juvenile residential correctional facility on the child's 18th birthday is automatically deemed eligible for MinnesotaCare upon termination or release until the child reaches the age of 21, and is exempt from the requirements of this section and section 256L.15. To be enrolled under this section, a child must complete an initial application for MinnesotaCare. The commissioner shall contact individuals enrolled under this section annually to ensure the individual continues to reside in the state and is interested in continuing MinnesotaCare coverage.

Subd. 9. **Firefighters; volunteer ambulance attendants.** (a) For purposes of this subdivision, "qualified individual" means:

(1) a volunteer firefighter with a department as defined in section 299N.01, subdivision 2, who has passed the probationary period; and

(2) a volunteer ambulance attendant as defined in section 144E.001, subdivision 15.

(b) A qualified individual who documents to the satisfaction of the commissioner status as a qualified individual by completing and submitting a one-page form developed by the commissioner is eligible for MinnesotaCare without meeting other eligibility requirements of this chapter, but must pay premiums equal to the average expected capitation rate for adults with no children paid under section 256L.12. Individuals eligible under this subdivision shall receive coverage for the benefit set provided to adults with no children.

256L.09 RESIDENCY.

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

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

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

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

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

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

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

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

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

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

256L.11 PROVIDER PAYMENT.

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

Subd. 3. **Inpatient hospital services.** Inpatient hospital services provided under section 256L.03, subdivision 3, shall be paid for as provided in subdivisions 4 to 6.

Subd. 6. **Enrollees 18 or older.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees eligible under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, shall be as provided for under paragraph (c).

(a) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.

(b) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the lesser of:

(1) the amount remaining in the enrollee's benefit limit; or

(2) charges submitted for the inpatient hospital services less any co-payment established under section 256L.03, subdivision 4.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the enrollee for the amount of the reduction.

(c) For admissions occurring on or after July 1, 2011, for single adults and households without children who are eligible under section 256L.04, subdivision 7, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits up to the $10,000 annual inpatient benefit limit, minus any co-payment required under section 256L.03, subdivision 5. Inpatient services paid directly by the commissioner under this paragraph do not include chemical dependency hospital-based and residential treatment.

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 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, general assistance medical care, 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. MinnesotaCare enrollees who were formerly eligible for general assistance medical care pursuant to section 256D.03, subdivision 3, within six months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant to section 256D.03, subdivision 4, paragraph (c), must 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 9530.6660.

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.15 PREMIUMS.

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

(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

(c) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the

first day of the month following the month in which eligibility is approved. This exemption applies for 12 months.

(d) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their families shall have their premiums waived by the commissioner in accordance with section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. An individual must document status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums.

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

(1) payment by check;

(2) payment by credit card;

(3) payment by recurring automatic checking withdrawal;

(4) payment by onetime electronic transfer of funds;

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

(6) payment by using state tax refund payments.

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

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

Subd. 2. **Sliding fee scale; monthly 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) Children in families whose gross income is above 275 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 premium scale specified in paragraph (d) with the exception that children in families with income at or below 200 percent of the federal poverty guidelines shall pay no premiums. For purposes of paragraph (d), "minimum" means a monthly premium of $4.

(d) The following premium scale is established for individuals and families with gross family incomes of 275 percent of the federal poverty guidelines or less:

Federal Poverty Guideline Range	Percent of Average Gross Monthly Income
0-45%	minimum
46-54%	$4 or 1.1% of family income, whichever is greater
55-81%	1.6%

82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
165-191%	4.6%
192-219%	5.6%
220-248%	6.5%
249-275%	7.2%

256L.17 ASSET REQUIREMENT FOR MINNESOTACARE.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply.

(a) "Asset" means cash and other personal property, as well as any real property, that a family or individual owns which has monetary value.

(b) "Homestead" means the home that is owned by, and is the usual residence of, the family or individual, together with the surrounding property which is not separated from the home by intervening property owned by others. Public rights-of-way, such as roads that run through the surrounding property and separate it from the home, will not affect the exemption of the property. "Usual residence" includes the home from which the family or individual is temporarily absent due to illness, employment, or education, or because the home is temporarily not habitable due to casualty or natural disaster.

(c) "Net asset" means the asset's fair market value minus any encumbrances including, but not limited to, liens and mortgages.

Subd. 2. **Limit on total assets.** (a) Effective July 1, 2002, or upon federal approval, whichever is later, in order to be eligible for the MinnesotaCare program, a household of two or more persons must not own more than $20,000 in total net assets, and a household of one person must not own more than $10,000 in total net assets.

(b) For purposes of this subdivision, assets are determined according to section 256B.056, subdivision 3c, except that workers' compensation settlements received due to a work-related injury shall not be considered.

(c) State-funded MinnesotaCare is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify assets. Enrollees who become eligible for federally funded medical assistance shall be terminated from state-funded MinnesotaCare and transferred to medical assistance.

Subd. 3. **Documentation.** (a) The commissioner of human services shall require individuals and families, at the time of application or renewal, to indicate on a form developed by the commissioner whether they satisfy the MinnesotaCare asset requirement.

(b) The commissioner may require individuals and families to provide any information the commissioner determines necessary to verify compliance with the asset requirement, if the commissioner determines that there is reason to believe that an individual or family has assets that exceed the program limit.

Subd. 4. **Penalties.** Individuals or families who are found to have knowingly misreported the amount of their assets as described in this section shall be subject to the penalties in section 256.98. The commissioner shall present recommendations on additional penalties to the 1998 legislature.

Subd. 5. **Exemption.** This section does not apply to pregnant women or children. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.