State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 2334

03/11/2019 Authored by Moran and Morrison
The bill was read for the first time and referred to the Committee on Health and Human Services Policy
03/18/2019 Adoption of Report: Placed on the General Register as Amended
Read for the Second Time
05/20/2019 Pursuant to Rule 4.20, returned to the Committee on Health and Human Services Policy

A bill for an act

relating to human services; modifying policy provisions governing health care; amending Minnesota Statutes 2018, sections 62U.03; 62U.04, subdivision 11; 256.01, subdivision 29; 256B.04, subdivision 21; 256B.056, subdivisions 1a, 4, 7, 7a, 10; 256B.0561, subdivision 2; 256B.057, subdivision 1; 256B.0575, subdivision 2; 256B.0625, subdivisions 1, 27; 256B.0751; 256B.0753, subdivision 1, by adding a subdivision; 256B.75; 256L.03, subdivision 1; 256L.15, subdivision 1; repealing Minnesota Statutes 2018, sections 62U.15, subdivision 2; 256B.057, subdivision 8; 256B.0752; 256B.79, subdivision 7; 256L.04, subdivision 13.

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

Section 1. Minnesota Statutes 2018, section 62U.03, is amended to read:

62U.03 PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS.

(a) By January 1, 2010, health plan companies shall include health care homes in their provider networks and by July 1, 2010, shall pay a care coordination fee for their members who choose to enroll in health care homes certified by the ~~commissioners of health and human services~~ commissioner under section 256B.0751. Health plan companies shall develop payment conditions and terms for the care coordination fee for health care homes participating in their network in a manner that is consistent with the system developed under section 256B.0753. Nothing in this section shall restrict the ability of health plan companies to selectively contract with health care providers, including health care homes. Health plan companies may reduce or reallocate payments to other providers to ensure that implementation of care coordination payments is cost neutral.

(b) By July 1, 2010, the commissioner of management and budget shall implement the care coordination payments for participants in the state employee group insurance program.

The commissioner of management and budget may reallocate payments within the health care system in order to ensure that the implementation of this section is cost neutral.

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

Sec. 2. Minnesota Statutes 2018, section 62U.04, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 3. Minnesota Statutes 2018, section 256.01, subdivision 29, is amended to read:

Subd. 29. **State medical review team.** (a) To ensure the timely processing of determinations of disability by the commissioner's state medical review team under sections 256B.055, ~~subdivision~~ subdivisions 7, paragraph (b), and 12; and 256B.057, subdivision 9, ~~and 256B.055, subdivision 12,~~ the commissioner shall review all medical evidence ~~submitted by county agencies with a referral~~ and seek ~~additional~~ information from providers, applicants, and enrollees to support the determination of disability where necessary. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

(b) Prior to a denial or withdrawal of a requested determination of disability due to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is necessary and appropriate to a determination of disability, and (2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

(c) The commissioner shall provide the chairs of the legislative committees with jurisdiction over health and human services finance and budget the following information on the activities of the state medical review team by February 1 of each year:

(1) the number of applications to the state medical review team that were denied, approved, or withdrawn;

(2) the average length of time from receipt of the application to a decision;

(3) the number of appeals, appeal results, and the length of time taken from the date the person involved requested an appeal for a written decision to be made on each appeal;

(4) for applicants, their age, health coverage at the time of application, hospitalization history within three months of application, and whether an application for Social Security or Supplemental Security Income benefits is pending; and

(5) specific information on the medical certification, licensure, or other credentials of the person or persons performing the medical review determinations and length of time in that position.

(d) Any appeal made under section 256.045, subdivision 3, of a disability determination made by the state medical review team must be decided according to the timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be immediately reviewed by the chief human services judge.

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

Sec. 4. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A, or is licensed as a home care provider by the Department of Health under chapter 144A and has a home and community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state. The commissioner may exempt a rehabilitation agency from termination or denial that would otherwise be required under this paragraph, if the rehabilitation agency:

(1) is unable to retain Medicare certification and enrollment solely due to a lack of billing to the Medicare program;

(2) meets all other applicable Medicare certification requirements based on an on-site review completed by the commissioner of health; and

(3) serves primarily a pediatric population.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a

list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(g)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

(h) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the

provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

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

Sec. 5. Minnesota Statutes 2018, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. **Income and assets generally.** (a)(1) Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the Supplemental Security Income program shall be used, except as provided under subdivision 3, paragraph (a), clause (6).

(2) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year. Effective upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, and Social Security payments are not counted as income.

(b)(1) The modified adjusted gross income methodology as defined in ~~the Affordable Care Act~~ United States Code, title 42, section 1396a(e)(14), shall be used for eligibility categories based on:

(i) children under age 19 and their parents and relative caretakers as defined in section 256B.055, subdivision 3a;

(ii) children ages 19 to 20 as defined in section 256B.055, subdivision 16;

(iii) pregnant women as defined in section 256B.055, subdivision 6;

(iv) infants as defined in sections 256B.055, subdivision 10, and 256B.057, subdivision ~~8~~ 1; and

(v) adults without children as defined in section 256B.055, subdivision 15.

For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

(2) For individuals whose income eligibility is determined using the modified adjusted gross income methodology in clause (1), :

(i) the commissioner shall subtract from the individual's modified adjusted gross income an amount equivalent to five percent of the federal poverty guidelines.; and

(ii) the individual's current monthly income and household size is used to determine eligibility for the 12-month eligibility period. If an individual's income is expected to vary month to month, eligibility is determined based on the income predicted for the 12-month eligibility period.

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

Sec. 6. Minnesota Statutes 2018, section 256B.056, subdivision 4, is amended to read:

Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal poverty guidelines. Effective January 1, 2000, and each successive January, recipients of Supplemental Security Income may have an income up to the Supplemental Security Income standard in effect on that date.

(b) ~~Effective January 1, 2014,~~ To be eligible for medical assistance~~,~~ under section 256B.055, subdivision 3a, a parent or caretaker relative may have an income up to 133 percent of the federal poverty guidelines for the household size.

(c) To be eligible for medical assistance under section 256B.055, subdivision 15, a person may have an income up to 133 percent of federal poverty guidelines for the household size.

(d) To be eligible for medical assistance under section 256B.055, subdivision 16, a child age 19 to 20 may have an income up to 133 percent of the federal poverty guidelines for the household size.

(e) To be eligible for medical assistance under section 256B.055, subdivision 3a, a child under age 19 may have income up to 275 percent of the federal poverty guidelines for the household size ~~or an equivalent standard when converted using modified adjusted gross income methodology as required under the Affordable Care Act. Children who are enrolled in medical assistance as of December 31, 2013, and are determined ineligible for medical assistance because of the elimination of income disregards under modified adjusted gross~~

~~income methodology as defined in subdivision 1a remain eligible for medical assistance under the Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3, until the date of their next regularly scheduled eligibility redetermination as required in subdivision 7a~~.

(f) In computing income to determine eligibility of persons under paragraphs (a) to (e) who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Laws 94-566, section 503; 99-272; and 99-509. For persons eligible under paragraph (a), veteran aid and attendance benefits and Veterans Administration unusual medical expense payments are considered income to the recipient.

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

Sec. 7. Minnesota Statutes 2018, section 256B.056, subdivision 7, is amended to read:

Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. A redetermination of eligibility must occur every 12 months.

(b) For a person eligible for an insurance affordability program who reports a change that makes the person eligible for medical assistance, eligibility is available for the month the change was reported and for three months prior to the month the change was reported, if the person was eligible in those prior months.

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

Sec. 8. Minnesota Statutes 2018, section 256B.056, subdivision 7a, is amended to read:

Subd. 7a. **Periodic renewal of eligibility.** (a) The commissioner shall make an annual redetermination of eligibility based on information contained in the enrollee's case file and other information available to the agency, including but not limited to information accessed through an electronic database, without requiring the enrollee to submit any information when sufficient data is available for the agency to renew eligibility.

(b) If the commissioner cannot renew eligibility in accordance with paragraph (a), the commissioner must provide the enrollee with a prepopulated renewal form containing eligibility information available to the agency and permit the enrollee to submit the form with any corrections or additional information to the agency and sign the renewal form via any of the modes of submission specified in section 256B.04, subdivision 18.

(c) An enrollee who is terminated for failure to complete the renewal process may subsequently submit the renewal form and required information within four months after

the date of termination and have coverage reinstated without a lapse, if otherwise eligible under this chapter.

(d) Notwithstanding paragraph (a), ~~individuals~~ a person who is eligible under subdivision 5 shall be ~~required to renew eligibility~~ subject to a review of the person's income every six months.

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

Sec. 9. Minnesota Statutes 2018, section 256B.056, subdivision 10, is amended to read:

Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the 60-day postpartum period to update their income and asset information and to submit any required income or asset verification.

(b) The commissioner shall determine the eligibility of private-sector health care coverage for infants less than one year of age eligible under section 256B.055, subdivision 10, or 256B.057, subdivision 1, paragraph ~~(b)~~ (c), and shall pay for private-sector coverage if this is determined to be cost-effective.

(c) The commissioner shall verify assets and income for all applicants, and for all recipients upon renewal.

(d) The commissioner shall utilize information obtained through the electronic service established by the secretary of the United States Department of Health and Human Services and other available electronic data sources in Code of Federal Regulations, title 42, sections 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish standards to define when information obtained electronically is reasonably compatible with information provided by applicants and enrollees, including use of self-attestation, to accomplish real-time eligibility determinations and maintain program integrity.

(e) Each person applying for or receiving medical assistance under section 256B.055, subdivision 7, and any other person whose resources are required by law to be disclosed to determine the applicant's or recipient's eligibility must authorize the commissioner to obtain information from financial institutions to identify unreported accounts as required in section 256.01, subdivision 18f. If a person refuses or revokes the authorization, the commissioner may determine that the applicant or recipient is ineligible for medical assistance. For purposes of this paragraph, an authorization to identify unreported accounts meets the requirements of the Right to Financial Privacy Act, United States Code, title 12, chapter 35, and need not be furnished to the financial institution.

(f) County and tribal agencies shall comply with the standards established by the commissioner for appropriate use of the asset verification system specified in section 256.01, subdivision 18f.

EFFECTIVE DATE. This section is effective upon implementation of Minnesota Statutes, section 256.01, subdivision 18f. The commissioner of human services shall notify the revisor of statutes when this section is effective.

Sec. 10. Minnesota Statutes 2018, section 256B.0561, subdivision 2, is amended to read:

Subd. 2. **Periodic data matching.** (a) ~~Beginning April 1, 2018,~~ The commissioner shall conduct periodic data matching to identify recipients who, based on available electronic data, may not meet eligibility criteria for the public health care program in which the recipient is enrolled. The commissioner shall conduct data matching for medical assistance or MinnesotaCare recipients at least once during a recipient's 12-month period of eligibility.

(b) If data matching indicates a recipient may no longer qualify for medical assistance or MinnesotaCare, the commissioner must notify the recipient and allow the recipient no more than 30 days to confirm the information obtained through the periodic data matching or provide a reasonable explanation for the discrepancy to the state or county agency directly responsible for the recipient's case. If a recipient does not respond within the advance notice period or does not respond with information that demonstrates eligibility or provides a reasonable explanation for the discrepancy within the 30-day time period, the commissioner shall terminate the recipient's eligibility in the manner provided for by the laws and regulations governing the health care program for which the recipient has been identified as being ineligible.

(c) The commissioner shall not terminate eligibility for a recipient who is cooperating with the requirements of paragraph (b) and needs additional time to provide information in response to the notification.

(d) A recipient whose eligibility was terminated according to paragraph (b) may be eligible for medical assistance no earlier than the first day of the month in which the recipient provides information that demonstrates the recipient's eligibility.

~~(d)~~ (e) Any termination of eligibility for benefits under this section may be appealed as provided for in sections 256.045 to 256.0451, and the laws governing the health care programs for which eligibility is terminated.

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

Sec. 11. Minnesota Statutes 2018, section 256B.057, subdivision 1, is amended to read:

Subdivision 1. **Infants and pregnant women.** (a) An infant less than two years of age ~~or a pregnant woman~~ is eligible for medical assistance if the ~~individual's~~ infant's countable household income is equal to or less than ~~275~~ 283 percent of the federal poverty guideline for the same household size ~~or an equivalent standard when converted using modified adjusted gross income methodology as required under the Affordable Care Act~~. Medical assistance for an uninsured infant younger than two years of age may be paid with federal funds available under title XXI of the Social Security Act and the state children's health insurance program, for an infant with countable income above 275 percent and equal to or less than 283 percent of the federal poverty guideline for the household size.

(b) A pregnant woman is eligible for medical assistance if the woman's countable income is equal to or less than 278 percent of the federal poverty guideline for the applicable household size.

~~(b)~~ (c) An infant born to a woman who was eligible for and receiving medical assistance on the date of the child's birth shall continue to be eligible for medical assistance without redetermination until the child's first birthday.

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

Sec. 12. Minnesota Statutes 2018, section 256B.0575, subdivision 2, is amended to read:

Subd. 2. **Reasonable expenses.** For the purposes of subdivision 1, paragraph (a), clause (9), reasonable expenses are limited to expenses that have not been previously used as a deduction from income and were not:

(1) for long-term care expenses incurred during a period of ineligibility as defined in section 256B.0595, subdivision 2;

(2) incurred more than three months before the month of application associated with the current period of eligibility;

(3) for expenses incurred by a recipient that are duplicative of services that are covered under chapter 256B; ~~or~~

(4) nursing facility expenses incurred without a timely assessment as required under section 256B.0911~~.~~; or

(5) for private room fees incurred by an assisted living client as defined in section 144G.01, subdivision 3.

EFFECTIVE DATE. This section is effective August 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 13. Minnesota Statutes 2018, section 256B.0625, subdivision 1, is amended to read:

Subdivision 1. **Inpatient hospital services.** (a) Medical assistance covers inpatient hospital services performed by hospitals holding Medicare certifications for the services performed. ~~A second medical opinion is required prior to reimbursement for elective surgeries requiring a second opinion. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion prior to reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and the criteria and standards are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether a second medical opinion is required, made in accordance with rules governing that decision, is not subject to administrative appeal.~~

(b) When determining medical necessity for inpatient hospital services, the medical review agent shall follow industry standard medical necessity criteria in determining the following:

(1) whether a recipient's admission is medically necessary;

(2) whether the inpatient hospital services provided to the recipient were medically necessary;

(3) whether the recipient's continued stay was or will be medically necessary; and

(4) whether all medically necessary inpatient hospital services were provided to the recipient.

The medical review agent will determine medical necessity of inpatient hospital services, including inpatient psychiatric treatment, based on a review of the patient's medical condition and records, in conjunction with industry standard evidence-based criteria to ensure consistent and optimal application of medical appropriateness criteria.

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

Sec. 14. Minnesota Statutes 2018, section 256B.0625, subdivision 27, is amended to read:

Subd. 27. **Organ and tissue transplants.** ~~All organ transplants must be performed at transplant centers meeting united network for organ sharing criteria or at Medicare-approved~~

~~organ transplant centers.~~ Organ and tissue transplants are a covered service. Stem cell or bone marrow transplant centers must meet the standards established by the Foundation for the Accreditation of Hematopoietic Cell Therapy.

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

Sec. 15. Minnesota Statutes 2018, section 256B.0751, is amended to read:

256B.0751 HEALTH CARE HOMES.

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

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

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

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

~~(e)~~ (d) "Personal clinician" means a physician licensed under chapter 147, a physician assistant licensed and practicing under chapter 147A, or an advanced practice nurse licensed and registered to practice under chapter 148.

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

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

(1) emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians;

(2) focus on delivering high-quality, efficient, and effective health care services;

(3) encourage patient-centered care, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate

in decision making and care plan development, and providing care that is appropriate to the patient's race, ethnicity, and language;

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

(5) ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an assessment of health risks and chronic conditions;

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

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

(8) incorporate measures of quality, resource use, cost of care, and patient experience;

(9) ensure the use of health information technology and systematic follow-up, including the use of patient registries; and

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

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

(c) For the purposes of developing and implementing these standards, the ~~commissioners~~ commissioner may use the expedited rulemaking process under section 14.389.

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

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

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

Subd. 4. **Alternative models and waivers of requirements.** (a) Nothing in this section shall preclude the continued development of existing medical or health care home projects currently operating or under development by the commissioner of human services or preclude the commissioner of human services from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs under section 256B.69, subdivisions 23 and 28, are enrolled in managed care long-term care programs under section 256B.69, subdivision 6b, are dually eligible for Medicare and medical assistance, are in the waiting period for Medicare, or who have other primary coverage.

(b) The commissioner ~~of health~~ shall waive health care home certification requirements if an applicant demonstrates that compliance with a certification requirement will create a major financial hardship or is not feasible, and the applicant establishes an alternative way to accomplish the objectives of the certification requirement.

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

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

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

Subd. 7. **Outreach.** ~~Beginning July 1, 2009,~~ The commissioner of human services shall encourage state health care program enrollees who have a complex or chronic condition to select a primary care clinic with clinicians who have been certified as health care homes.

Subd. 8. **Coordination with local services.** The health care home and the county shall coordinate care and services provided to patients enrolled with a health care home who have complex medical needs or a disability, and who need and are eligible for additional local services administered by counties, including but not limited to waivered services, mental health services, social services, public health services, transportation, and housing. The coordination of care and services must be as provided in the plan established by the patient and the health care home.

Subd. 9. **Pediatric care coordination.** The commissioner of human services shall implement a pediatric care coordination service for children with high-cost medical or high-cost psychiatric conditions who are at risk of recurrent hospitalization or emergency room use for acute, chronic, or psychiatric illness, who receive medical assistance services. Care coordination services must be targeted to children not already receiving care coordination through another service and may include but are not limited to the provision of health care home services to children admitted to hospitals that do not currently provide care coordination. Care coordination services must be provided by care coordinators who are directly linked to provider teams in the care delivery setting, but who may be part of a community care team shared by multiple primary care providers or practices. For purposes of this subdivision, the commissioner of human services shall, to the extent possible, use the existing health care home certification and payment structure established under this section and section 256B.0753.

Subd. 10. **Health care homes advisory committee.** (a) The ~~commissioners of health and human services~~ commissioner shall establish a health care homes advisory committee to advise the ~~commissioners~~ commissioner on the ongoing statewide implementation of the health care homes program authorized in this section.

(b) The ~~commissioners~~ commissioner shall establish an advisory committee that includes representatives of the health care professions such as primary care providers; mental health providers; nursing and care coordinators; certified health care home clinics with statewide representation; health plan companies; state agencies; employers; academic researchers; consumers; and organizations that work to improve health care quality in Minnesota. At least 25 percent of the committee members must be consumers or patients in health care homes. The ~~commissioners~~ commissioner, in making appointments to the committee, shall ensure geographic representation of all regions of the state.

(c) The advisory committee shall advise the ~~commissioners~~ commissioner on ongoing implementation of the health care homes program, including, but not limited to, the following activities:

(1) implementation of certified health care homes across the state on performance management and implementation of benchmarking;

(2) implementation of modifications to the health care homes program based on results of the legislatively mandated health care homes evaluation;

(3) statewide solutions for engagement of employers and commercial payers;

(4) potential modifications of the health care homes rules or statutes;

(5) consumer engagement, including patient and family-centered care, patient activation in health care, and shared decision making;

(6) oversight for health care homes subject matter task forces or workgroups; and

(7) other related issues as requested by the ~~commissioners~~ commissioner.

(d) The advisory committee shall have the ability to establish subcommittees on specific topics. The advisory committee is governed by section 15.059. Notwithstanding section 15.059, the advisory committee does not expire.

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

Sec. 16. Minnesota Statutes 2018, section 256B.0753, subdivision 1, is amended to read:

Subdivision 1. **Development.** The commissioner of human services, in coordination with the commissioner of health, shall develop a payment system that provides per-person care coordination payments to health care homes certified under section 256B.0751 for providing care coordination services and directly managing on-site or employing care coordinators. The care coordination payments under this section are in addition to the quality incentive payments in section 256B.0754, subdivision 1. The care coordination payment system must vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination. In developing the criteria for care coordination payments, the commissioner shall consider the feasibility of including the additional time and resources needed by patients with limited English-language skills, cultural differences, or other barriers to health care. The commissioner may determine a schedule for phasing in care coordination fees such that the fees will be applied first to individuals who have, or are at risk of developing, complex or chronic health conditions. ~~Development of the payment system must be completed by January 1, 2010.~~

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

Sec. 17. Minnesota Statutes 2018, section 256B.0753, is amended by adding a subdivision to read:

Subd. 1a. **Definitions.** For the purposes of this section, the definitions in section 256B.0751, subdivision 1, apply.

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

Sec. 18. Minnesota Statutes 2018, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in ~~2016~~ 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process

is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

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

Sec. 19. Minnesota Statutes 2018, section 256L.03, subdivision 1, is amended to read:

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

(b) No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment

of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

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

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

Sec. 20. Minnesota Statutes 2018, section 256L.15, subdivision 1, is amended to read:

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

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

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

~~(d) For premiums effective August 1, 2015, and after, the commissioner, after consulting with the chairs and ranking minority members of the legislative committees with jurisdiction over human services, shall increase premiums under subdivision 2 for recipients based on June 2015 program enrollment. Premium increases shall be sufficient to increase projected revenue to the fund described in section 16A.724 by at least $27,800,000 for the biennium ending June 30, 2017. The commissioner shall publish the revised premium scale on the Department of Human Services website and in the State Register no later than June 15, 2015. The revised premium scale applies to all premiums on or after August 1, 2015, in place of the scale under subdivision 2.~~

~~(e) By July 1, 2015, the commissioner shall provide the chairs and ranking minority members of the legislative committees with jurisdiction over human services the revised~~

~~premium scale effective August 1, 2015, and statutory language to codify the revised premium schedule.~~

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

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

Sec. 21. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall renumber the provisions of Minnesota Statutes listed in column A to the references listed in column B.

Column A	Column B
256B.0751, subd. 1	62U.03, subd. 2
256B.0751, subd. 2	62U.03, subd. 3
256B.0751, subd. 3	62U.03, subd. 4
256B.0751, subd. 4	62U.03, subd. 5
256B.0751, subd. 5	62U.03, subd. 6
256B.0751, subd. 6	62U.03, subd. 7
256B.0751, subd. 7	62U.03, subd. 8
256B.0751, subd. 8	62U.03, subd. 9
256B.0751, subd. 9	62U.03, subd. 10
256B.0751, subd. 10	62U.03, subd. 11

(b) The revisor of statutes shall change the applicable references to Minnesota Statutes, section 256B.0751, to section 62U.03. The revisor shall make necessary cross-reference changes in Minnesota Statutes consistent with the renumbering. The revisor shall also make technical and other necessary changes to sentence structure to preserve the meaning of the text.

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

Sec. 22. **REPEALER.**

Minnesota Statutes 2018, sections 62U.15, subdivision 2; 256B.057, subdivision 8; 256B.0752; 256B.79, subdivision 7; and 256L.04, subdivision 13, are repealed.

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

62U.15 ALZHEIMER'S DISEASE; PREVALENCE AND SCREENING MEASURES.

Subd. 2. **Learning collaborative.** By July 1, 2012, the commissioner shall develop a health care home learning collaborative curriculum that includes screening and education on best practices regarding identification and management of Alzheimer's and other dementia patients under section 256B.0751, subdivision 5, for providers, clinics, care coordinators, clinic administrators, patient partners and families, and community resources including public health.

256B.057 ELIGIBILITY REQUIREMENTS FOR SPECIAL CATEGORIES.

Subd. 8. **Children under age two.** Medical assistance may be paid for a child under two years of age whose countable household income is above 275 percent of the federal poverty guidelines for the same household size but less than or equal to 280 percent of the federal poverty guidelines for the same household size or an equivalent standard when converted using modified adjusted gross income methodology as required under the Affordable Care Act.

256B.0752 HEALTH CARE HOME REPORTING REQUIREMENTS.

Subdivision 1. **Annual reports on implementation and administration.** The commissioners shall report annually to the legislature on the implementation and administration of the health care home model for state health care program enrollees in the fee-for-service, managed care, and county-based purchasing sectors beginning December 15, 2009, and each December 15 thereafter.

Subd. 2. **Evaluation reports.** The commissioners shall provide to the legislature comprehensive evaluations of the health care home model three years and five years after implementation. The report must include:

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

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

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

(4) measures of preventive care;

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

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

(7) estimated savings from implementation of the health care home model for the fee-for-service, managed care, and county-based purchasing sectors.

256B.79 INTEGRATED CARE FOR HIGH-RISK PREGNANT WOMEN.

Subd. 7. **Expiration.** This section expires June 30, 2019.

256L.04 ELIGIBLE PERSONS.

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.