CHAPTER 310–S.F.No. 3027

An act relating to human services; changing health care eligibility provisions; making changes to individualized education plan requirements; state health access program; children's health insurance reauthorization act; long-term care partnership; asset transfers; community clinics; dental benefits; prior authorization for health services; drug formulary committee; preferred drug list; multisource drugs; administrative uniformity committee; health plans; claims against the state; income standards for eligibility; prepaid health plans; amending Minnesota Statutes 2008, sections 62A.045; 62Q.80; 62S.24, subdivision 8; 256B.055, subdivision 10; 256B.057, subdivision 1; 256B.0571, subdivision 6; 256B.0625, subdivisions 13c, 13g, 25, 30, by adding a subdivision; 256L.04, subdivision 7b; Minnesota Statutes 2009 Supplement, sections 15C.13; 256B.032; 256B.056, subdivision 1c; 256B.0571, subdivision 8; 256B.0625, subdivisions 9, 13e, 26; 256B.69, subdivisions 5a, 23; 256D.03, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 62S; repealing Minnesota Statutes 2008, sections 256B.0571, subdivision 10; 256B.0595, subdivisions 1b, 2b, 3b, 4b, 5.

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

ARTICLE 1

INDIVIDUALIZED EDUCATION PLAN SERVICES

Section 1. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 26, is amended to read:

Subd. 26. **Special education services.** (a) Medical assistance covers medical services identified in a recipient's individualized education plan and covered under the medical assistance state plan. Covered services include occupational therapy, physical therapy, speech-language therapy, clinical psychological services, nursing services, school psychological services, school social work services, personal care assistants serving as management aides, assistive technology devices, transportation services, health assessments, and other services covered under the medical assistance state plan. Mental health services eligible for medical assistance reimbursement must be provided or coordinated through a children's mental health collaborative where a collaborative exists if the child is included in the collaborative operational target population. The provision or coordination of services does not require that the individual education plan be developed by the collaborative.

The services may be provided by a Minnesota school district that is enrolled as a medical assistance provider or its subcontractor, and only if the services meet all the requirements otherwise applicable if the service had been provided by a provider other than a school district, in the following areas: medical necessity, physician's orders, documentation, personnel qualifications, and prior authorization requirements. The

nonfederal share of costs for services provided under this subdivision is the responsibility of the local school district as provided in section 125A.74. Services listed in a child's individual education plan are eligible for medical assistance reimbursement only if those services meet criteria for federal financial participation under the Medicaid program.

(b) Approval of health-related services for inclusion in the individual education plan does not require prior authorization for purposes of reimbursement under this chapter. The commissioner may require physician review and approval of the plan not more than once annually or upon any modification of the individual education plan that reflects a change in health-related services.

(c) Services of a speech-language pathologist provided under this section are covered notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

(1) holds a masters degree in speech-language pathology;

(2) is licensed by the Minnesota Board of Teaching as an educational speech-language pathologist; and

(3) either has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(d) Medical assistance coverage for medically necessary services provided under other subdivisions in this section may not be denied solely on the basis that the same or similar services are covered under this subdivision.

(e) The commissioner shall develop and implement package rates, bundled rates, or per diem rates for special education services under which separately covered services are grouped together and billed as a unit in order to reduce administrative complexity.

(f) The commissioner shall develop a cost-based payment structure for payment of these services. Only costs reported through the designated Minnesota Department of Education data systems in distinct service categories qualify for inclusion in the cost-based payment structure. The commissioner shall reimburse claims submitted based on an interim rate, and shall settle at a final rate once the department has determined it. The commissioner shall notify the school district of the final rate. The school district has 60 days to appeal the final rate. To appeal the final rate, the school district shall file a written appeal request to the commissioner within 60 days of the date the final rate determination was mailed. The appeal request shall specify (1) the disputed items and (2) the name and address of the person to contact regarding the appeal.

(g) Effective July 1, 2000, medical assistance services provided under an individual education plan or an individual family service plan by local school districts shall not count against medical assistance authorization thresholds for that child.

(h) Nursing services as defined in section 148.171, subdivision 15, and provided as an individual education plan health-related service, are eligible for medical assistance payment if they are otherwise a covered service under the medical assistance program. Medical assistance covers the administration of prescription medications by a licensed nurse who is employed by or under contract with a school district when the administration of medications is identified in the child's individualized education plan. The simple administration of medications alone is not covered under medical assistance when

administered by a provider other than a school district or when it is not identified in the child's individualized education plan.

ARTICLE 2

STATE HEALTH ACCESS PROGRAM

Section 1. Minnesota Statutes 2008, section 62Q.80, is amended to read:

62Q.80 COMMUNITY-BASED HEALTH CARE COVERAGE PROGRAM.

Subdivision 1. **Scope.** (a) ~~A~~ Any community-based health care initiative may develop and operate ~~a~~ community-based health care coverage ~~program~~ programs that ~~offers~~ offer to eligible individuals and their dependents the option of purchasing through their employer health care coverage on a fixed prepaid basis without meeting the requirements of chapter 60A, 62A, 62C, 62D, 62M, 62N, 62Q, ~~or~~ 62T, or 62U, or any other law or rule that applies to entities licensed under these chapters.

(b) ~~The~~ Each initiative shall establish health outcomes to be achieved through the ~~program~~ programs and performance measurements in order to determine whether these outcomes have been met. The outcomes must include, but are not limited to:

(1) a reduction in uncompensated care provided by providers participating in the community-based health network;

(2) an increase in the delivery of preventive health care services; and

(3) health improvement for enrollees with chronic health conditions through the management of these conditions.

In establishing performance measurements, the initiative shall use measures that are consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures.

(c) Any program established under this section shall not constitute a financial liability for the state, in that any financial risk involved in the operation or termination of the program shall be borne by the community-based initiative and the participating health care providers.

Subd. 1a. **Demonstration project.** The commissioner of health and the commissioner of human services shall award ~~a~~ demonstration project ~~grant~~ grants to ~~a~~ community-based health care ~~initiative~~ initiatives to develop and operate ~~a~~ community-based health care coverage ~~program to operate within Carlton, Cook, Lake, and St. Louis Counties~~ programs in Minnesota. The demonstration ~~project~~ projects shall extend for five years and must comply with the requirements of this section.

Subd. 2. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Community-based" means located in or primarily relating to the community ~~of geographically contiguous political subdivisions~~, as determined by the board of a community-based health initiative that is served by the community-based health care coverage program.

(b) "Community-based health care coverage program" or "program" means a program administered by a community-based health initiative that provides health care

services through provider members of a community-based health network or combination of networks to eligible individuals and their dependents who are enrolled in the program.

(c) "Community-based health initiative" or "initiative" means a nonprofit corporation that is governed by a board that has at least 80 percent of its members residing in the community and includes representatives of the participating network providers and employers, or a county-based purchasing organization as defined in section 256B.692.

(d) "Community-based health network" means a contract-based network of health care providers organized by the community-based health initiative to provide or support the delivery of health care services to enrollees of the community-based health care coverage program on a risk-sharing or nonrisk-sharing basis.

(e) "Dependent" means an eligible employee's spouse or unmarried child who is under the age of 19 years.

Subd. 3. **Approval.** (a) Prior to the operation of a community-based health care coverage program, a community-based health initiative, defined in subdivision 2, paragraph (c), and receiving funds from the Department of Health, shall submit to the commissioner of health for approval the community-based health care coverage program developed by the initiative. Each community-based health initiative as defined in subdivision 2, paragraph (c), and receiving State Health Access Program (SHAP) grant funding shall submit to the commissioner of human services for approval prior to its operation the community-based health care coverage programs developed by the initiatives. The ~~commissioner~~ commissioners shall ensure that ~~the~~ each program meets the federal grant requirements and any requirements described in this section and is actuarially sound based on a review of appropriate records and methods utilized by the community-based health initiative in establishing premium rates for the community-based health care coverage ~~program~~ programs.

(b) Prior to approval, the commissioner shall also ensure that:

(1) the benefits offered comply with subdivision 8 and that there are adequate numbers of health care providers participating in the community-based health network to deliver the benefits offered under the program;

(2) the activities of the program are limited to activities that are exempt under this section or otherwise from regulation by the commissioner of commerce;

(3) the complaint resolution process meets the requirements of subdivision 10; and

(4) the data privacy policies and procedures comply with state and federal law.

Subd. 4. **Establishment.** The initiative shall establish and operate upon approval by the ~~commissioner~~ commissioners of health ~~a~~ and human services community-based health care coverage ~~program~~ programs. The operational structure established by the initiative shall include, but is not limited to:

(1) establishing a process for enrolling eligible individuals and their dependents;

(2) collecting and coordinating premiums from enrollees and employers of enrollees;

(3) providing payment to participating providers;

(4) establishing a benefit set according to subdivision 8 and establishing premium rates and cost-sharing requirements;

(5) creating incentives to encourage primary care and wellness services; and

(6) initiating disease management services, as appropriate.

Subd. 5. **Qualifying employees.** To be eligible for the community-based health care coverage program, an individual must:

(1) reside in or work within the designated community-based geographic area served by the program;

(2) be employed by a qualifying employer ~~or,~~ be an employee's dependent, or be self-employed on a full-time basis;

(3) not be enrolled in or have currently available health coverage, except for catastrophic health care coverage; and

(4) not be eligible for or enrolled in medical assistance~~,~~ or general assistance medical care, and not be enrolled in MinnesotaCare~~,~~ or Medicare.

Subd. 6. **Qualifying employers.** (a) To qualify for participation in the community-based health care coverage program, an employer must:

(1) employ at least one but no more than 50 employees at the time of initial enrollment in the program;

(2) pay its employees a median wage ~~of $12.50 per hour~~ that equals 350 percent of the federal poverty guidelines or less for an individual; and

(3) not have offered employer-subsidized health coverage to its employees for at least 12 months prior to the initial enrollment in the program. For purposes of this section, "employer-subsidized health coverage" means health care coverage for which the employer pays at least 50 percent of the cost of coverage for the employee.

(b) To participate in the program, a qualifying employer agrees to:

(1) offer health care coverage through the program to all eligible employees and their dependents regardless of health status;

(2) participate in the program for an initial term of at least one year;

(3) pay a percentage of the premium established by the initiative for the employee; and

(4) provide the initiative with any employee information deemed necessary by the initiative to determine eligibility and premium payments.

Subd. 7. **Participating providers.** Any health care provider participating in the community-based health network must accept as payment in full the payment rate established by the ~~initiative~~ initiatives and may not charge to or collect from an enrollee any amount in access of this amount for any service covered under the program.

Subd. 8. **Coverage.** (a) The ~~initiative~~ initiatives shall establish the health care benefits offered through the community-based health care coverage ~~program~~ programs. The benefits established shall include, at a minimum:

(1) child health supervision services up to age 18, as defined under section 62A.047; and

(2) preventive services, including:

(i) health education and wellness services;

(ii) health supervision, evaluation, and follow-up;

(iii) immunizations; and

(iv) early disease detection.

(b) Coverage of health care services offered by the program may be limited to participating health care providers or health networks. All services covered under the ~~program~~ programs must be services that are offered within the scope of practice of the participating health care providers.

(c) The ~~initiative~~ initiatives may establish cost-sharing requirements. Any co-payment or deductible provisions established may not discriminate on the basis of age, sex, race, disability, economic status, or length of enrollment in the ~~program~~ programs.

(d) If any of the ~~initiative~~ initiatives amends or alters the benefits offered through the program from the initial offering, ~~the~~ that initiative must notify the ~~commissioner~~ commissioners of health and human services and all enrollees of the benefit change.

Subd. 9. **Enrollee information.** (a) The ~~initiative~~ initiatives must provide an individual or family who enrolls in the program a clear and concise written statement that includes the following information:

(1) health care services that are ~~provided~~ covered under the program;

(2) any exclusions or limitations on the health care services ~~offered~~ covered, including any cost-sharing arrangements or prior authorization requirements;

(3) a list of where the health care services can be obtained and that all health care services must be provided by or through a participating health care provider or community-based health network;

(4) a description of the program's complaint resolution process, including how to submit a complaint; how to file a complaint with the commissioner of health; and how to obtain an external review of any adverse decisions as provided under subdivision 10;

(5) the conditions under which the program or coverage under the program may be canceled or terminated; and

(6) a precise statement specifying that this program is not an insurance product and, as such, is exempt from state regulation of insurance products.

(b) The ~~commissioner~~ commissioners of health and human services must approve a copy of the written statement prior to the operation of the program.

Subd. 10. **Complaint resolution process.** (a) The ~~initiative~~ initiatives must establish a complaint resolution process. The process must make reasonable efforts to resolve complaints and to inform complainants in writing of the initiative's decision within 60 days of receiving the complaint. Any decision that is adverse to the enrollee shall include a description of the right to an external review as provided in paragraph (c) and how to exercise this right.

(b) The ~~initiative~~ initiatives must report any complaint that is not resolved within 60 days to the commissioner of health.

(c) The ~~initiative~~ initiatives must include in the complaint resolution process the ability of an enrollee to pursue the external review process provided under section 62Q.73

with any decision rendered under this external review process binding on the ~~initiative~~ initiatives.

Subd. 11. **Data privacy.** The ~~initiative~~ initiatives shall establish data privacy policies and procedures for the program that comply with state and federal data privacy laws.

Subd. 12. **Limitations on enrollment.** (a) The ~~initiative~~ initiatives may limit enrollment in the program. If enrollment is limited, a waiting list must be established.

(b) The ~~initiative~~ initiatives shall not restrict or deny enrollment in the program except for nonpayment of premiums, fraud or misrepresentation, or as otherwise permitted under this section.

(c) The ~~initiative~~ initiatives may require a certain percentage of participation from eligible employees of a qualifying employer before coverage can be offered through the program.

Subd. 13. **Report.** ~~(a) The~~ Each initiative shall submit quarterly status reports to the commissioner of health on January 15, April 15, July 15, and October 15 of each year, with the first report due January 15, 2008. ~~The~~ Each initiative receiving funding from the Department of Human Services shall submit status reports to the commissioner of human services as defined in the terms of contract with the Department of Human Services. Each status report shall include:

(1) the financial status of the program, including the premium rates, cost per member per month, claims paid out, premiums received, and administrative expenses;

(2) a description of the health care benefits offered and the services utilized;

(3) the number of employers participating, the number of employees and dependents covered under the program, and the number of health care providers participating;

(4) a description of the health outcomes to be achieved by the program and a status report on the performance measurements to be used and collected; and

(5) any other information requested by the ~~commissioner~~ commissioners of health, human services, or commerce or the legislature.

~~(b) The initiative shall contract with an independent entity to conduct an evaluation of the program to be submitted to the commissioners of health and commerce and the legislature by January 15, 2010. The evaluation shall include:~~

~~(1) an analysis of the health outcomes established by the initiative and the performance measurements to determine whether the outcomes are being achieved;~~

~~(2) an analysis of the financial status of the program, including the claims to premiums loss ratio and utilization and cost experience;~~

~~(3) the demographics of the enrollees, including their age, gender, family income, and the number of dependents;~~

~~(4) the number of employers and employees who have been denied access to the program and the basis for the denial;~~

~~(5) specific analysis on enrollees who have aggregate medical claims totaling over $5,000 per year, including data on the enrollee's main diagnosis and whether all the medical claims were covered by the program;~~

~~(6) number of enrollees referred to state public assistance programs;~~

~~(7) a comparison of employer-subsidized health coverage provided in a comparable geographic area to the designated community-based geographic area served by the program, including, to the extent available:~~

~~(i) the difference in the number of employers with 50 or fewer employees offering employer-subsidized health coverage;~~

~~(ii) the difference in uncompensated care being provided in each area; and~~

~~(iii) a comparison of health care outcomes and measurements established by the initiative; and~~

~~(8) any other information requested by the commissioner of health or commerce.~~

Subd. 14. **Sunset.** This section expires ~~December 31, 2012~~ August 31, 2014.

ARTICLE 3

CHILDREN'S HEALTH INSURANCE REAUTHORIZATION ACT (CHIPRA)

Section 1. Minnesota Statutes 2008, section 256B.055, subdivision 10, is amended to read:

Subd. 10. **Infants.** Medical assistance may be paid for an infant less than one year of age, whose mother was eligible for and receiving medical assistance at the time of birth ~~and who remains in the mother's household~~ or who is in a family with countable income that is equal to or less than the income standard established under section 256B.057, subdivision 1.

Sec. 2. Minnesota Statutes 2008, section 256B.057, subdivision 1, is amended to read:

Subdivision 1. **Infants and pregnant women.** (a)(1) An infant less than one year of age or a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse is eligible for medical assistance if countable family income is equal to or less than 275 percent of the federal poverty guideline for the same family size. For purposes of this subdivision, "countable family income" means the amount of income considered available using the methodology of the AFDC program under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, except for the earned income disregard and employment deductions.

(2) For applications processed within one calendar month prior to the effective date, eligibility shall be determined by applying the income standards and methodologies in effect prior to the effective date for any months in the six-month budget period before that date and the income standards and methodologies in effect on the effective date for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(b)(1) [Expired, 1Sp2003 c 14 art 12 s 19]

(2) For applications processed within one calendar month prior to July 1, 2003, eligibility shall be determined by applying the income standards and methodologies in effect prior to July 1, 2003, for any months in the six-month budget period before July 1, 2003, and the income standards and methodologies in effect on the expiration date for any

months in the six-month budget period on or after July 1, 2003. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(3) An amount equal to the amount of earned income exceeding 275 percent of the federal poverty guideline, up to a maximum of the amount by which the combined total of 185 percent of the federal poverty guideline plus the earned income disregards and deductions allowed under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), Public Law 104-193, exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants less than one year of age.

(c) Dependent care and child support paid under court order shall be deducted from the countable income of pregnant women.

(d) An infant born ~~on or after January 1, 1991,~~ 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~~, as long as the child remains in the woman's household~~.

ARTICLE 4

LONG-TERM CARE PARTNERSHIP

Section 1. Minnesota Statutes 2008, section 62S.24, subdivision 8, is amended to read:

Subd. 8. **Exchange for long-term care partnership policy; addition of policy rider.** (a) ~~If authorized by federal law or a federal waiver is granted~~ With respect to the long-term care partnership program referenced in section 256B.0571, issuers of long-term care policies may voluntarily exchange a current long-term care insurance policy for a long-term care partnership policy that meets the requirements of Public Law 109-171, section 6021, after the effective date of the state plan amendment implementing the partnership program in this state. The exchange may be in the form of: (1) an amendment or rider; or (2) a disclosure statement indicating that the coverage is now partnership qualified.

(b) ~~If authorized by federal law or a federal waiver is granted~~ With respect to the long-term care partnership program referenced in section 256B.0571, ~~allowing~~ to allow an existing long-term care insurance policy to qualify as a partnership policy by addition of: (1) a policy rider, or amendment; or (2) a disclosure statement, the issuer of the policy is authorized to add the rider, amendment, or disclosure statement to the policy after the effective date of the state plan amendment implementing the partnership program in this state.

(c) The commissioner, in cooperation with the commissioner of human services, shall pursue any federal law changes or waivers necessary to allow the implementation of paragraphs (a) and (b).

Sec. 2. **[62S.312] CONSUMER PROTECTION STANDARDS FOR LONG-TERM CARE PARTNERSHIP POLICIES.**

To qualify as a long-term care partnership policy under this chapter, long-term care insurance policies must meet the requirements for being tax qualified as defined in section 7702B(b) of the Internal Revenue Code and meet certain consumer protection

requirements in Section 6021(a)(1)(B)(5)(A) of the Deficit Reduction Act of 2005, Public Law 109-171, which are taken from the National Association of Insurance Commissioners (NAIC) Model Act and Regulation of 2000. Insurance carriers must certify for each policy form to be included in the long-term care partnership that the form complies with the requirements of the NAIC Model Act and Regulation of 2000 as implemented in sections 62S.05 to 62S.11; 62S.13 to 62S.18; 62S.19; 62S.20, subdivisions 1 to 5; 62S.21; 62S.22; 62S.24; 62S.25; 62S.266; 62S.28; 62S.29; 62S.30; and 62S.31.

Sec. 3. Minnesota Statutes 2008, section 256B.0571, subdivision 6, is amended to read:

Subd. 6. **Partnership policy.** "Partnership policy" means a long-term care insurance policy that meets the ~~requirements under subdivision 10 and~~ criteria in sections 62S.23, subdivision 1, paragraph (b), and 62S.312 and was issued on or after ~~the effective date of the state plan amendment implementing the partnership program in Minnesota. Policies that are exchanged or that have riders or endorsements added on or after the effective date of the state plan amendment as authorized by the commissioner of commerce qualify as a partnership policy~~ July 1, 2006, or exchanged on or after July 1, 2006, under the provisions of section 62S.24, subdivision 8.

Sec. 4. Minnesota Statutes 2009 Supplement, section 256B.0571, subdivision 8, is amended to read:

Subd. 8. **Program established.** (a) The commissioner, in cooperation with the commissioner of commerce, shall establish the Minnesota partnership for long-term care program to provide for the financing of long-term care through a combination of private insurance and medical assistance.

(b) An individual becomes eligible to participate in the partnership program by meeting the requirements of either clause (1) or (2):

(1) the individual may qualify as a beneficiary of a partnership policy that ~~either (i) is issued on or after the effective date of the state plan amendment implementing the partnership plan in Minnesota, or (ii) qualifies as a partnership policy as authorized by the commissioner of commerce~~ meets the criteria under subdivision 6. To be eligible under this clause, the individual must be a Minnesota resident at the time coverage first became effective under the partnership policy; or

(2) the individual may qualify as a beneficiary of a policy recognized under subdivision 17.

Sec. 5. **REPEALER.**

Minnesota Statutes 2008, section 256B.0571, subdivision 10, is repealed.

ARTICLE 5

MODIFICATION TO PROHIBITIONS ON ASSET TRANSFERS

Section 1. **REPEALER.**

Minnesota Statutes 2008, section 256B.0595, subdivisions 1b, 2b, 3b, 4b, and 5, are repealed.

ARTICLE 6

COMMUNITY CLINICS

Section 1. Minnesota Statutes 2009 Supplement, section 256B.032, is amended to read:

256B.032 ELIGIBLE VENDORS OF MEDICAL CARE.

(a) Effective January 1, 2011, the commissioner shall establish performance thresholds for health care providers included in the provider peer grouping system developed by the commissioner of health under section 62U.04. The thresholds shall be set at the 10th percentile of the combined cost and quality measure used for provider peer grouping, and separate thresholds shall be set for hospital and physician services.

(b) Beginning January 1, 2012, any health care provider with a combined cost and quality score below the threshold set in paragraph (a) shall be prohibited from enrolling as a vendor of medical care in the medical assistance, general assistance medical care, or MinnesotaCare programs, and shall not be eligible for direct payments under those programs or for payments made by managed care plans under their contracts with the commissioner under section 256B.69 or 256L.12. A health care provider that is prohibited from enrolling as a vendor or receiving payments under this paragraph may reenroll effective January 1 of any subsequent year if the provider's most recent combined cost and quality score exceeds the threshold established in paragraph (a).

(c) Notwithstanding paragraph (b), a provider may continue to participate as a vendor or as part of a managed care plan provider network if the commissioner determines that a contract with the provider is necessary to ensure adequate access to health care services.

(d) By January 15, 2013, the commissioner shall report to the legislature on the impact of this section. The commissioner's report shall include information on:

(1) the providers falling below the thresholds as of January 1, 2012;

(2) the volume of services and cost of care provided to enrollees in the medical assistance, general assistance medical care, or MinnesotaCare programs in the 12 months prior to January 1, 2012, by providers falling below the thresholds;

(3) providers who fell below the thresholds but continued to be eligible vendors under ~~paragraph~~ paragraphs (c) and (e);

(4) the estimated cost savings achieved by not contracting with providers who do not meet the performance thresholds; and

(5) recommendations for increasing the threshold levels of performance over time.

(e) Federally qualified health centers and rural health clinics are exempt from the requirements of paragraph (b).

Sec. 2. Minnesota Statutes 2008, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, public health clinic services~~, and the services of a clinic meeting the criteria established in rule by the commissioner~~. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42,

section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

ARTICLE 7

DENTAL BENEFIT SET

Section 1. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years~~, and only if provided in conjunction with a posterior extraction or scheduled outpatient facility procedure, or~~ as except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma~~. Panoramic x-rays may be taken~~ or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full-mouth debridement, limited to one every five years.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children ~~that are medically necessary~~ and pregnant women. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only; ~~and~~

(3) application of fluoride varnish is covered once every six months~~.~~; and

(4) orthodontia is eligible for coverage for children only.

ARTICLE 8

PRIOR AUTHORIZATION FOR HEALTH SERVICES

Section 1. Minnesota Statutes 2008, section 256B.0625, subdivision 25, is amended to read:

Subd. 25. **Prior authorization required.** The commissioner shall publish in the ~~State Register~~ Minnesota health care programs provider manual and on the department's Web site a list of health services that require prior authorization, as well as the criteria and standards used to select health services on the list. The list and the criteria and standards used to formulate it are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether prior authorization is required for a health service is not subject to administrative appeal.

ARTICLE 9

DRUG FORMULARY COMMITTEE

Section 1. Minnesota Statutes 2008, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered

outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least ~~quarterly~~ twice per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

ARTICLE 10

PREFERRED DRUG LIST

Section 1. Minnesota Statutes 2008, section 256B.0625, subdivision 13g, is amended to read:

Subd. 13g. **Preferred drug list.** (a) The commissioner shall adopt and implement a preferred drug list by January 1, 2004. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred drug list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall publish the preferred drug list annually in the State Register and shall maintain an accurate and up-to-date list on the agency Web site.

(b) The commissioner may add to, delete from, and otherwise modify the preferred drug list, after consulting with the Formulary Committee and appropriate medical specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred drug list as part of the administration of the supplemental drug rebate program. Reimbursement for prescription drugs not on the preferred drug list may be subject to prior authorization~~, unless the drug manufacturer signs a supplemental rebate contract~~.

(d) For purposes of this subdivision, "preferred drug list" means a list of prescription drugs within designated therapeutic classes selected by the commissioner, for which prior authorization based on the identity of the drug or class is not required.

(e) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

ARTICLE 11

MULTISOURCE DRUGS

Section 1. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the

charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. Effective July 1, 2009, the actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus 15 percent. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a ~~generically equivalent product is available~~ maximum allowable cost has been set for a multisource drug, payment shall be on the basis of ~~the actual acquisition cost of the generic drug, or on~~ the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider or the amount established for Medicare by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis

C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

ARTICLE 12

ADMINISTRATIVE UNIFORMITY COMMITTEE

Section 1. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

Subd. 8d. **Home infusion therapy services.** Home infusion therapy services provided by home infusion therapy pharmacies must be paid the lower of the submitted charge or the combined payment rates for component services typically provided.

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 2. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. Effective July 1, 2009, the actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus 15 percent. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug.

The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, or on the maximum allowable cost established by the commissioner.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider or the amount established for Medicare by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

EFFECTIVE DATE. This section is effective upon federal approval.

ARTICLE 13

HEALTH PLANS

Section 1. Minnesota Statutes 2008, section 62A.045, is amended to read:

62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS.

(a) As a condition of doing business in Minnesota or providing coverage to residents of Minnesota covered by this section, each health insurer shall comply with the

requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171, including any federal regulations adopted under that act, to the extent that it imposes a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal act prior to the effective date provided for that provision in the federal act. The commissioner shall enforce this section.

For the purpose of this section, "health insurer" includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by contract legally responsible to pay a claim for a healthcare item or service for an individual receiving benefits under paragraph (b).

(b) No ~~health~~ plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256; 256B; or 256D or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health ~~carrier~~ insurer providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

(c) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state agency. The state agency may assert its rights under this section within three years of the date the service was rendered. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

(d) Notwithstanding any law to the contrary, when a person covered by a ~~health~~ plan offered by a health insurer receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the Department of Human Services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the health ~~carrier~~ insurer for those services. If the commissioner of human services notifies the health ~~carrier~~ insurer that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the health ~~carrier~~ insurer must be issued directly to the commissioner. Submission by the department to the health ~~carrier~~ insurer of the claim on a Department of Human Services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the health ~~carrier~~ insurer relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the health ~~carrier~~ insurer to the provider or the commissioner as required by this section.

(e) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health ~~carrier~~ insurer, the health ~~carrier~~ insurer shall not impose requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

~~(f) For the purpose of this section, health plan includes coverage offered by community integrated service networks, any plan governed under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461, and coverage offered under the exclusions listed in section 62A.011, subdivision 3, clauses (2), (6), (9), (10), and (12).~~

Sec. 2. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 23, is amended to read:

Subd. 23. **Alternative services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans that are offered by a demonstration provider or by an entity that is directly or indirectly wholly owned or controlled by a demonstration provider to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. All enforcement and rulemaking powers available under chapters 62D, 62M, and 62Q are hereby granted to the commissioner of health with respect to Medicare-approved special needs plans with which the commissioner contracts to provide Medicaid services under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent

mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement under this section projects for persons with developmental disabilities. The commissioner may capitate payments for ICF/MR services, waivered services for developmental disabilities, including case management services, day training and habilitation and alternative active treatment services, and other services as approved by the state and by the federal government. Case management and active treatment must be individualized and developed in accordance with a person-centered plan. Costs under these projects may not exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003, and until four years after the pilot project implementation date, subcontractor participation in the long-term care developmental disability pilot is limited to a nonprofit long-term care system providing ICF/MR services, home and community-based waiver services, and in-home services to no more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature prior to expansion of the developmental disability pilot project. This paragraph expires four years after the implementation date of the pilot project.

(c) Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. The process for approval of these programs shall begin only after the commissioner receives grant money in an amount sufficient to cover the state share of the administrative and actuarial costs to implement the programs during state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an account in the special revenue fund and are appropriated to the commissioner to be used solely for the purpose of PACE administrative and actuarial costs. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community alternatives for disabled individuals or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed

costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. Until July 1, 2009, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. Notwithstanding whether expansion occurs under this paragraph, in determining MnDHO payment rates and risk adjustment methods for contract years starting in 2012, the commissioner must consider the methods used to determine county allocations for home and community-based program participants. If necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs for home and community-based services, the commissioner shall achieve the reduction by maintaining the base rate for contract years 2010 and 2011 for services provided under the community alternatives for disabled individuals waiver at the same level as for contract year 2009. The commissioner may apply other reductions to MnDHO rates to implement decreases in provider payment rates required by state law. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans for further expansion of MnDHO projects shall be presented to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007.

(g) Notwithstanding section 256B.0261, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

ARTICLE 14

CLAIMS AGAINST THE STATE

Section 1. Minnesota Statutes 2009 Supplement, section 15C.13, is amended to read:

15C.13 DISTRIBUTION TO PRIVATE PLAINTIFF IN CERTAIN ACTIONS.

If the prosecuting attorney intervenes at the outset in an action brought by a person under section 15C.05, the person is entitled to receive not less than 15 percent or more than 25 percent of any recovery in proportion to the person's contribution to the conduct of the action. If the prosecuting attorney does not intervene in the action at any time, the person is entitled to receive not less than 25 percent or more than 30 percent of any recovery of the civil penalty and damages, or settlement, as the court determines is reasonable. If the prosecuting attorney does not intervene in the action at the outset but subsequently intervenes, the person is entitled to receive not less than 15 percent or more than 30 percent of any recovery, as the court determines is reasonable based on the person's participation in the action before the prosecuting attorney intervened. For recoveries whose distribution is governed by federal code or rule, the basis for calculating the portion

of the recovery the person is entitled to receive shall not include amounts reserved for distribution to the federal government or designated in their use by federal code or rule.

ARTICLE 15

PREPAID HEALTH PLANS

Section 1. Minnesota Statutes 2009 Supplement, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year basis beginning January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B, 256D, and 256L, established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan's payment rate under section 256B.692 for the prepaid medical assistance and general assistance medical care programs 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. 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, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) Effective for services rendered on or after January 1, 2009, through December 31, 2009, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance and general assistance medical care programs. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~The return of the withhold under this paragraph is not subject to the requirements of paragraph (c).~~

(e) Effective for services provided on or after January 1, 2010, the commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.

(f) Effective for services rendered on or after January 1, 2010, through December 31, 2010, the commissioner shall withhold 3.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(g) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall withhold four percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(h) Effective for services rendered on or after January 1, 2012, through December 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(i) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(j) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance and prepaid general assistance medical care programs. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(k) 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.

(l) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(m) The return of the withhold under paragraph (d) and paragraphs (f) to (j) is not subject to the requirements of paragraph (c).

ARTICLE 16

INCOME STANDARDS FOR ELIGIBILITY

Section 1. Minnesota Statutes 2009 Supplement, section 256B.056, subdivision 1c, is amended to read:

Subd. 1c. **Families with children income methodology.** (a)(1) [Expired, 1Sp2003 c 14 art 12 s 17]

(2) For applications processed within one calendar month prior to July 1, 2003, eligibility shall be determined by applying the income standards and methodologies in effect prior to July 1, 2003, for any months in the six-month budget period before July 1, 2003, and the income standards and methodologies in effect on July 1, 2003, for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(3) For children ages one through 18 whose eligibility is determined under section 256B.057, subdivision 2, the following deductions shall be applied to income counted toward the child's eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: $90 work expense, dependent care, and child support paid under court order. This clause is effective October 1, 2003.

(b) For families with children whose eligibility is determined using the standard specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable earned income shall be disregarded for up to four months and the following deductions shall be applied to each individual's income counted toward eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: dependent care and child support paid under court order.

(c) If the four-month disregard in paragraph (b) has been applied to the wage earner's income for four months, the disregard shall not be applied again until the wage earner's income has not been considered in determining medical assistance eligibility for 12 consecutive months.

(d) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services <u>except that the income standards shall not go below those in effect on July 1, 2009</u>.

(e) For children age 18 or under, annual gifts of $2,000 or less by a tax-exempt organization to or for the benefit of the child with a life-threatening illness must be disregarded from income.

Sec. 2. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, is amended to read:

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare for applicants and recipients defined in paragraph (c), except as provided in paragraph (d), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of $1,000 per assistance unit. General assistance medical care is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify their assets. Enrollees who become eligible for medical assistance shall be terminated and transferred to medical assistance. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; or

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization.

(b) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services except that the income standards shall not go below those in effect on July 1, 2009.

(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (f).

(d) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month general assistance medical care eligibility period, until their six-month renewal.

(e) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph (d), an individual must complete a new application.

(f) Applicants and recipients eligible under paragraph (a), clause (2), item (i), are exempt from the MinnesotaCare enrollment requirements in this subdivision if they:

(1) have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration;

(2) fail to meet the requirements of section 256L.09, subdivision 2;

(3) are homeless as defined by United States Code, title 42, section 11301, et seq.;

(4) are classified as end-stage renal disease beneficiaries in the Medicare program;

(5) are enrolled in private health care coverage as defined in section 256B.02, subdivision 9;

(6) are eligible under paragraph (k);

(7) receive treatment funded pursuant to section 254B.02; or

(8) reside in the Minnesota sex offender program defined in chapter 246B.

(g) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization.

(h) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph (d) and submitted to the county agency shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraphs (d), (f), and (g).

(i) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5, and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

(j) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(k) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal

hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(l) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

(m) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(n) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(o) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101, subsection (a), paragraph (15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services.

(p) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(q) Effective July 1, 2003, general assistance medical care emergency services end.

Sec. 3. Minnesota Statutes 2008, section 256L.04, subdivision 7b, is amended to read:

Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income limits under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services <u>except that the income standards shall not go below those in effect on July 1, 2009</u>.

Presented to the governor May 7, 2010

Signed by the governor May 11, 2010, 10:57 a.m.