

**256L.03 COVERED HEALTH SERVICES.**

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

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

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

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

Subd. 1b. **Pregnant women; eligibility for full medical assistance services.** A pregnant woman enrolled in MinnesotaCare is eligible for coverage of all services provided under the medical assistance program according to chapter 256B retroactive to the date of conception. Co-payments totaling \$30 or more, paid after the date of conception, shall be refunded.

Subd. 2. **Alcohol and drug dependency.** Beginning July 1, 1993, covered health services shall include individual outpatient treatment of alcohol or drug dependency by a qualified health professional or outpatient program.

Persons who may need chemical dependency services under the provisions of this chapter shall be assessed by a local agency as defined under section 254B.01, and under the assessment provisions of section 254A.03, subdivision 3. A local agency or managed care plan under contract with the Department of Human Services must place a person in need of chemical dependency services as provided in Minnesota Rules, parts 9530.6600 to 9530.6660. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for consolidated chemical dependency treatment fund services provided under the provisions of chapter 254B shall receive chemical dependency treatment services under the provisions of chapter 254B only if:

- (1) they have exhausted the chemical dependency benefits offered under this chapter; or
- (2) an assessment indicates that they need a level of care not provided under the provisions of this chapter.

Recipients of covered health services under the children's health plan, as provided in Minnesota Statutes 1990, section 256.936, and as amended by Laws 1991, chapter 292, article 4, section 17, and recipients of covered health services enrolled in the children's health plan or the MinnesotaCare program after October 1, 1992, pursuant to Laws 1992, chapter 549, article 4, sections 5 and 17, are eligible to receive alcohol and drug dependency benefits under this subdivision.

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

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

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

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

Subd. 3a. **Interpreter services.** Covered services include sign and spoken language interpreter services that assist an enrollee in obtaining covered health care services.

Subd. 3b. **Chiropractic services.** MinnesotaCare covers the following chiropractic services: medically necessary exams, manual manipulation of the spine, and x-rays.

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

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

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

(1) \$3 per prescription for adult enrollees;

(2) \$25 for eyeglasses for adult enrollees;

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

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

(5) a family deductible equal to \$2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next-higher five cent increment.

(b) Paragraph (a) does not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 447.51.

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

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

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

(f) The commissioner shall increase co-payments for covered services in a manner sufficient to reduce the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(g) The cost-sharing changes authorized under paragraph (f) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

Subd. 5a. [Repealed, 2002 c 220 art 15 s 27]

Subd. 6. **Lien.** When the state agency provides, pays for, or becomes liable for covered health services, the agency shall have a lien for the cost of the covered health services upon any and all causes of action accruing to the enrollee, or to the enrollee's legal representatives, as a result of the occurrence that necessitated the payment for the covered health services. All liens under this section shall be subject to the provisions of section 256.015. For purposes of this subdivision, "state agency" includes participating entities, under contract with the commissioner according to section 256L.121.

**History:** 1986 c 444; 1992 c 549 art 4 s 4,19; 1992 c 603 s 31; 1993 c 247 art 4 s 2-4,11; 1993 c 345 art 9 s 3; 1993 c 366 s 26; 1994 c 625 art 8 s 50,51,72; 1995 c 207 art 6 s 12; 1995 c 234 art 6 s 4,5; 1997 c 225 art 1 s 1-3; 1998 c 407 art 5 s 10-16; 1999 c 245 art 4 s 89,90; 2000 c 340 s 15; 1Sp2001 c 9 art 2 s 60; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 12 s 71; 2004 c 228 art 1 s 75; 1Sp2005 c 4 art 2 s 17; art 8 s 57-59; 2006 c 282 art 16 s 12; 2007 c 147 art 4 s 8; art 5 s 20-22; art 8 s 29,30; 2009 c 79 art 5 s 54; 2009 c 173 art 1 s 35; art 3 s 19; 1Sp2010 c 1 art 16 s 33; 1Sp2011 c 9 art 6 s 72; 2012 c 247 art 1 s 18; 2013 c 108 art 1 s 36-41; 2014 c 291 art 9 s 5; 2015 c 71 art 11 s 48