CHAPTER 256L

MINNESOTACARE

256L.01 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of this chapter, the following terms shall have the meanings given them.

Subd. 1a. **Child.** "Child" means an individual under 21 years of age.

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

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

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

Subd. 3a. **Family.** (a) Except as provided in paragraphs (c) and (d), "family" has the meaning given for family and family size as defined in Code of Federal Regulations, title 26, section 1.36B-1.

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

(c) For an individual who does not expect to file a federal tax return and does not expect to be claimed as a dependent for the applicable tax year, "family" has the meaning given in Code of Federal Regulations, title 42, section 435.603(f)(3).

(d) For a married couple, "family" has the meaning given in Code of Federal Regulations, title 42, section 435.603(f)(4).

Subd. 4. [Repealed, 2009 c 173 art 3 s 26]

Subd. 4a. [Repealed, 2013 c 108 art 1 s 68]

Subd. 5. **Income.** "Income" has the meaning given for modified adjusted gross income, as defined in Code of Federal Regulations, title 26, section 1.36B-1, and means a household's projected annual income for the applicable tax year.

Subd. 6. **MNsure.** "MNsure" means the state health benefit exchange as defined in section 62V.02.

Subd. 7. **Participating entity.** "Participating entity" means a health carrier as defined in section 62A.01, subdivision 2; a county-based purchasing plan established under section 256B.692; an accountable care

organization or other entity operating a health care delivery systems demonstration project authorized under section 256B.0755; an entity operating a county integrated health care delivery network pilot project authorized under section 256B.0756; or a network of health care providers established to offer services under MinnesotaCare.

History: *1986 c 444; 1987 c 403 art 2 s 63; 1988 c 689 art 2 s 137; 1989 c 282 art 3 s 33; 1990 c 568 art 3 s 14; 1992 c 549 art 4 s 2,19; 1993 c 345 art 9 s 1; 1998 c 407 art 5 s 7; 2000 c 444 art 2 s 5; 2002 c 374 art 10 s 13; 2005 c 98 art 2 s 15; 1Sp2005 c 4 art 8 s 55,56; 2007 c 147 art 5 s 18,19; 2009 c 173 art 3 s 18; 2013 c 108 art 1 s 28-32,67; 2015 c 71 art 11 s 46,47; 2016 c 189 art 19 s 20,21; 2021 c 30 art 1 s 19*

256L.02 PROGRAM ADMINISTRATION.

Subdivision 1. **Purpose.** The MinnesotaCare program is established to promote access to appropriate health care services to ensure healthy children and adults.

Subd. 2. **Commissioner's duties.** (a) The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide covered health services for eligible persons. Payment for these services shall be made to all participating entities under contract with the commissioner. The commissioner shall adopt rules to administer the MinnesotaCare program. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the Department of Human Services.

(b) A toll-free telephone number and website must be used to provide information about medical programs and to promote access to the covered services.

Subd. 3. [Repealed, 2015 c 71 art 11 s 65]

Subd. 4. [Repealed, 1Sp2001 c 9 art 2 s 76; 2002 c 277 s 31]

Subd. 5. **Federal approval.** (a) The commissioner of human services shall seek federal approval to implement the MinnesotaCare program under this chapter as a basic health program. In any agreement with the Centers for Medicare and Medicaid Services to operate MinnesotaCare as a basic health program, the commissioner shall seek to include procedures to ensure that federal funding is predictable, stable, and sufficient to sustain ongoing operation of MinnesotaCare. These procedures must address issues related to the timing of federal payments, payment reconciliation, enrollee risk adjustment, and minimization of state financial risk. The commissioner shall consult with the commissioner of management and budget, when developing the proposal for establishing MinnesotaCare as a basic health program to be submitted to the Centers for Medicare and Medicaid Services.

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

Subd. 6. **Coordination with MNsure.** MinnesotaCare shall be considered a public health care program for purposes of chapter 62V.

History: *1986 c 444; 1987 c 403 art 2 s 63; 1988 c 689 art 2 s 137; 1989 c 282 art 3 s 34; 1992 c 549 art 4 s 3,19; 1993 c 4 s 28; 1993 c 247 art 4 s 11; 1993 c 345 art 9 s 2; 1994 c 625 art 8 s 72; art 13 s 1;*

1995 c 234 art 6 s 3; 1997 c 225 art 3 s 3; 1998 c 407 art 5 s 8,9; 1Sp2001 c 5 art 14 s 1; 2009 c 101 art 2 s 109; 1Sp2011 c 9 art 6 s 71; 2013 c 108 art 1 s 33-35,67; 2025 c 20 s 209

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, nonemergency medical transportation services, personal care assistance and case management services, community first services and supports under section 256B.85, behavioral health home services under section 256B.0757, housing stabilization services under section 256B.051, and nursing home or intermediate care facilities services.

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

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

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 special education services and 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. **Substance use disorder.** Beginning July 1, 1993, covered health services shall include individual outpatient treatment of substance use disorder by a qualified health professional or outpatient program.

Persons who may need substance use disorder services under the provisions of this chapter must be assessed by a qualified professional as defined in section 245G.11, subdivisions 1 and 5, 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 offer services to a person in need of substance use disorder services based on the recommendations of section 245G.05. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for behavioral health fund services provided under the provisions of chapter 254B shall receive substance use disorder treatment services under the provisions of chapter 254B only if:

(1) they have exhausted the substance use disorder 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 substance use disorder 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 substance use disorder 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 9505.0505 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 for individuals under the age of 21: (1) medically necessary exams; (2) manual manipulation of the spine; and (3) x-rays.

[See Note.]

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) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain 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.

(c) The cost-sharing changes authorized under paragraph (b) 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.

(d) Cost-sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

(e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

(f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

(g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

(h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention or crisis assessment as defined in section 256B.0624, subdivision 2.

[See Note.]

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; 2016 c 125 s 15; 2016 c 158 art 1 s 148,214; 1Sp2017 c 6 art 4 s 55-57; 2020 c 115 art 3 s 33; 2021 c 30 art 13 s 82,83; 2022 c 98 art 4 s 51; 2023 c 50 art 2 s 55; 2023 c 57 art 2 s 63; 2023 c 70 art 1 s 38,39; 2024 c 127 art 55 s 14; 2025 c 38 art 4 s 40; 1Sp2025 c 3 art 8 s 31*

NOTE: The amendment to subdivision 3b by Laws 2025, First Special Session chapter 3, article 8, section 31, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 31, the effective date.

NOTE: The amendment to subdivision 5 by Laws 2023, chapter 70, article 1, section 39, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2023, chapter 70, article 1, section 39, the effective date.

256L.031 [Repealed, 2013 c 108 art 1 s 68]

256L.035 [Repealed, 2007 c 147 art 5 s 41]

256L.04 ELIGIBLE PERSONS.

Subdivision 1. **Families with children.** Families with children with family income above 133 percent of the federal poverty guidelines and equal to or less than 200 percent of the federal poverty guidelines for

the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18 shall apply unless otherwise specified. Children under age 19 with family income at or below 200 percent of the federal poverty guidelines and who are ineligible for medical assistance by sole reason of the application of federal household composition rules for medical assistance are eligible for MinnesotaCare.

Subd. 1a. **Social Security number required.** Individuals and families applying for MinnesotaCare coverage must provide a Social Security number if required by Code of Federal Regulations, title 45, section 155.310 (a)(3).

Subd. 1b. [Repealed, 2013 c 108 art 1 s 68]

Subd. 1c. **General requirements.** To be eligible for MinnesotaCare, a person must meet the eligibility requirements of this section. A person eligible for MinnesotaCare shall not be considered a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered through MNsure under chapter 62V.

Subd. 2. **Third-party liability and other medical support.** Individuals and families may cooperate with the state agency to identify potentially liable third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited to, complying with the notice requirements in section 256B.056, subdivision 9, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third-party payments.

Subd. 2a. [Repealed, 2016 c 189 art 19 s 31]

Subd. 3. [Repealed, 1998 c 407 art 5 s 48]

Subd. 4. [Repealed, 1998 c 407 art 5 s 48]

Subd. 5. [Repealed, 1998 c 407 art 5 s 48]

Subd. 6. [Repealed, 1998 c 407 art 5 s 48]

Subd. 7. **Single adults and households with no children.** The definition of eligible persons includes all individuals and families with no children who have incomes that are above 133 percent and equal to or less than 200 percent of the federal poverty guidelines for the applicable family size.

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

Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income limits under this section annually on January 1 as provided in Code of Federal Regulations, title 26, section 1.36B-1(h).

Subd. 8. [Repealed, 2016 c 189 art 19 s 31]

Subd. 9. [Repealed, 2013 c 107 art 4 s 22; 2013 c 108 art 1 s 68]

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is available to citizens or nationals of the United States; lawfully present noncitizens as defined in Code of Federal Regulations, title 45, section 155.20; and undocumented noncitizens. For purposes of this subdivision, 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. Families with children who are citizens or nationals of the United

States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) Notwithstanding subdivisions 1 and 7, eligible persons include families and individuals who are ineligible for medical assistance by reason of immigration status and who have incomes equal to or less than 200 percent of federal poverty guidelines, except that these persons may be eligible for emergency medical assistance under section 256B.06, subdivision 4.

(c) For purposes of this subdivision, enrollment in MinnesotaCare for undocumented noncitizens who are age 18 years old or older is limited to those enrolled as of June 15, 2025. Notwithstanding paragraphs (a) and (b), undocumented noncitizens who are age 18 years old or older are ineligible for MinnesotaCare beginning January 1, 2026.

Subd. 10a. [Repealed, 2013 c 108 art 1 s 68]

Subd. 11. [Repealed, 1Sp2005 c 4 art 8 s 88]

Subd. 12. **Persons in detention.** An applicant or enrollee residing in a correctional or detention facility is not eligible for MinnesotaCare, unless the applicant or enrollee is awaiting disposition of charges.

Subd. 13. MS 2018 [Repealed, 2020 c 115 art 3 s 40]

Subd. 14. **Coordination with medical assistance.** (a) Individuals eligible for medical assistance under chapter 256B are not eligible for MinnesotaCare under this section.

(b) The commissioner shall coordinate eligibility and coverage to ensure that individuals transitioning between medical assistance and MinnesotaCare have seamless eligibility and access to health care services.

History: *1986 c 444; 1992 c 549 art 4 s 5,19; 1993 c 247 art 4 s 5; 1993 c 345 art 9 s 4-6; 1994 c 625 art 8 s 52-55,72; art 13 s 2; 1995 c 234 art 6 s 6-9; 1997 c 85 art 3 s 9; 1997 c 203 art 12 s 1; 1997 c 225 art 1 s 4-8; 1998 c 407 art 5 s 17-25; 1999 c 245 art 4 s 91-94; 1Sp2003 c 14 art 12 s 73,74; 2005 c 98 art 2 s 16; 1Sp2005 c 4 art 8 s 61-63; 2006 c 282 art 17 s 35; 2007 c 13 art 1 s 25; 2007 c 147 art 4 s 9; art 5 s 23; art 13 s 2; 2008 c 358 art 3 s 6,7; 2009 c 79 art 5 s 55-58; 2009 c 173 art 1 s 36; art 3 s 22,23; 2010 c 310 art 16 s 3; 2010 c 382 s 51; 1Sp2011 c 9 art 6 s 74,75; 2013 c 108 art 1 s 42-48,67; 2015 c 71 art 11 s 49,50; 2016 c 189 art 19 s 22-24; 2021 c 30 art 1 s 20; 2023 c 70 art 16 s 15; 2024 c 127 art 54 s 8; 1Sp2025 c 2 s 1*

256L.05 APPLICATION PROCEDURES.

Subdivision 1. **Application assistance and information availability.** (a) Applicants may submit applications online, in person, by mail, or by phone in accordance with the Affordable Care Act, and by any other means by which medical assistance applications may be submitted. Applicants may submit applications through MNsure or through the MinnesotaCare program. Applications and application assistance must be made available at provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced-price meals, community health offices, Women, Infants and Children (WIC) program sites, Head Start program sites, public housing councils, crisis nurseries, child care centers, early childhood education and preschool program sites, legal aid offices, and libraries, and at any other locations at which medical assistance applications must be made available. These sites may accept applications and forward the forms to the commissioner or local county human services agencies that choose to participate as an enrollment site. Otherwise, applicants may apply directly to the commissioner or to participating local county human services agencies.

(b) Application assistance must be available for applicants choosing to file an online application through MNsure.

Subd. 1a. **Person authorized to apply on applicant's behalf.** Beginning January 1, 1999, a family member who is age 18 or over or who is an authorized representative, as defined in the medical assistance program, may apply on an applicant's behalf.

Subd. 1b. [Repealed, 2015 c 71 art 11 s 65]

Subd. 1c. [Repealed, 2015 c 71 art 11 s 65]

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

Subd. 2a. **Eligibility and coverage.** For purposes of this chapter, an individual is eligible for MinnesotaCare following a determination by the commissioner that the individual meets the eligibility criteria for the applicable period of eligibility. For an individual required to pay a premium, coverage is only available in each month of the applicable period of eligibility for which a premium is paid.

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. The effective date of coverage for new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's modified adjusted gross income and the adjusted premium begins in the month the new family member is added.

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

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

(d) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, subdivision 1, paragraph (c), is the first day of the month following the month in which eligibility is approved.

Subd. 3a. **Redetermination of eligibility.** (a) An enrollee's eligibility must be redetermined on an annual basis. The period of eligibility is the entire calendar year following the year in which eligibility is redetermined. Eligibility redeterminations shall occur during the open enrollment period for qualified health plans as specified in Code of Federal Regulations, title 45, section 155.410(e)(3).

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. Coverage begins as provided in section 256L.06.

Subd. 3b. [Repealed, 2013 c 108 art 1 s 68]

Subd. 3c. [Repealed, 2015 c 71 art 11 s 65]

Subd. 4. **Application processing.** The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than 45 days from the date that the application is received by the Department of Human Services as set forth in Code of Federal Regulations, title 42, section 435.912.

Subd. 5. [Repealed, 2015 c 71 art 11 s 65]

Subd. 6. **Referral of veterans.** The commissioner shall ensure that all applicants for MinnesotaCare who identify themselves as veterans are referred to a county veterans service officer for assistance in applying to the United States Department of Veterans Affairs for any veterans benefits for which they may be eligible.

History: *1986 c 444; 1987 c 403 art 2 s 63; 1988 c 689 art 2 s 137; 1992 c 549 art 4 s 6,19; 1993 c 247 art 4 s 6; 1994 c 625 art 8 s 72; art 13 s 3; 1995 c 234 art 6 s 10; 1996 c 451 art 5 s 10; 1997 c 225 art 1 s 9-11; 1997 c 251 s 26; 1998 c 407 art 5 s 26-31; 1999 c 245 art 4 s 95,96; 2000 c 488 art 9 s 27; 1Sp2001 c 9 art 2 s 61; 2002 c 277 s 28; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 12 s 75,76; 1Sp2005 c 4 art 8 s 64-67; 2007 c 147 art 5 s 24-27; 2008 c 358 art 3 s 8; 2009 c 79 art 5 s 59-62; 2009 c 173 art 1 s 37; art 3 s 24; 2010 c 200 art 1 s 13-16; 1Sp2010 c 1 art 24 s 8; 1Sp2011 c 9 art 6 s 76,77,97; 2012 c 216 art 13 s 17; 2013 c 108 art 1 s 49-52,67; 2015 c 71 art 11 s 51-54; 2016 c 189 art 19 s 25; 2021 c 30 art 1 s 21; 2023 c 55 art 9 s 19*

256L.06 PREMIUM ADMINISTRATION.

Subdivision 1. [Repealed, 1998 c 407 art 5 s 48]

Subd. 2. [Repealed, 1998 c 407 art 5 s 48]

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

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

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

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month following the month for which the premium was due. Persons disenrolled for nonpayment may not reenroll prior to the first day of the month following the payment of an amount equal to two months' premiums.

(e) The commissioner shall forgive the past-due premium for persons disenrolled under paragraph (d) prior to issuing a premium invoice for the fourth month following disenrollment.

History: *1986 c 444; 1987 c 403 art 2 s 63; 1988 c 689 art 2 s 137; 1989 c 282 art 3 s 35; 1992 c 549 art 4 s 7,19; 1993 c 247 art 4 s 7; 1993 c 345 art 9 s 7; 1994 c 625 art 13 s 4; 1995 c 234 art 8 s 56; 1998 c 407 art 5 s 32; 1999 c 245 art 4 s 97; 1Sp2001 c 9 art 2 s 62; 2002 c 277 s 29; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 12 s 77; 1Sp2005 c 4 art 8 s 68; 2008 c 358 art 3 s 9; 1Sp2011 c 9 art 6 s 97; 2013 c 108 art 1 s 53; 2015 c 71 art 11 s 55; 2016 c 189 art 19 s 26*

256L.07 ELIGIBILITY FOR MINNESOTACARE.

Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month in which the commissioner sends advance notice according to Code of Federal Regulations, title 42, section 431.211, that indicates the income of a family or individual exceeds program income limits.

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

(b) Notwithstanding paragraph (a), an individual who has access through a spouse's or parent's employer to subsidized health coverage that is deemed minimum essential coverage under Code of Federal Regulations, title 26, section 1.36B-2, is eligible for MinnesotaCare if the employee's portion of the annual premium for employee and dependent coverage exceeds the required contribution percentage, as defined for premium tax credit eligibility under United States Code, title 26, section 36B(c)(2)(C)(i)(II), as indexed according to item (iv) of that section, of the individual's household income for the coverage year.

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

Subd. 2a. [Repealed, 2007 c 147 art 5 s 41]

Subd. 3. **Other health coverage.** (a) To be eligible, a family or individual must not have minimum essential health coverage, as defined by section 5000A of the Internal Revenue Code.

(b) For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to have minimum essential health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

Subd. 4. **Families with children in need of substance use disorder treatment.** Premiums for families with children when a parent has been determined to be in need of substance use disorder treatment pursuant to an assessment conducted by the county under section 260E.20, subdivision 1, paragraph (g), or in need of chemical dependency treatment pursuant to a case plan under section 260C.201, subdivision 6, or 260C.212, who are eligible for MinnesotaCare under section 256L.04, subdivision 1, may be paid by the county of residence of the person in need of treatment for one year from the date the family is determined to be eligible or if the family is currently enrolled in MinnesotaCare from the date the person is determined to be in need of substance use disorder treatment. Upon renewal, the family is responsible for any premiums owed under

section 256L.15. If the family is not currently enrolled in MinnesotaCare, the local county human services agency shall determine whether the family appears to meet the eligibility requirements and shall assist the family in applying for the MinnesotaCare program.

Subd. 5. [Repealed, 2013 c 108 art 1 s 68]

Subd. 6. [Repealed, 2010 c 200 art 1 s 21]

Subd. 7. [Repealed, 1Sp2011 c 9 art 6 s 97]

Subd. 8. [Repealed, 2013 c 108 art 1 s 68]

Subd. 9. [Repealed, 2013 c 108 art 1 s 68]

History: *1986 c 444; 1992 c 549 art 4 s 8,19; 1993 c 345 art 9 s 8; 1994 c 625 art 8 s 56,72; 1995 c 234 art 6 s 11-13; 1997 c 187 art 1 s 18; 1997 c 225 art 1 s 12; 1998 c 407 art 5 s 33; 1999 c 139 art 4 s 2; 1999 c 245 art 4 s 98; 1Sp2001 c 9 art 2 s 63; 2002 c 220 art 15 s 21,22; 2002 c 277 s 30; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 12 s 78,79; 2005 c 10 art 1 s 56; 2005 c 59 s 1; 1Sp2005 c 4 art 8 s 69-72; 2007 c 147 art 5 s 28,29; art 13 s 3; 2008 c 286 art 1 s 10; 2008 c 358 art 3 s 10; 2009 c 79 art 5 s 63-66; 1Sp2010 c 1 art 16 s 35; 2012 c 247 art 1 s 22; 2013 c 108 art 1 s 54-56,68; 2014 c 275 art 1 s 132; 2016 c 189 art 19 s 27; 1Sp2020 c 2 art 8 s 104; 1Sp2021 c 7 art 1 s 27; 2022 c 98 art 4 s 51; 2023 c 25 s 148*

256L.08 [Repealed, 1998 c 407 art 5 s 48]

256L.09 RESIDENCY.

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

Subd. 2. **Residency requirement.** To be eligible for health coverage under the MinnesotaCare program, individuals and families with children must meet the residency requirements as provided by Code of Federal Regulations, title 42, section 435.403.

Subd. 3. [Repealed, 1998 c 407 art 5 s 48]

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

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

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

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

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

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

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

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

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

History: *1986 c 444; 1992 c 549 art 4 s 10,19; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72; 1997 c 225 art 1 s 14; 1998 c 407 art 5 s 34-36; 2007 c 147 art 5 s 30; 1Sp2011 c 9 art 6 s 78; 2013 c 108 art 1 s 57; 2016 c 158 art 2 s 108*

256L.10 APPEALS.

If the commissioner suspends, reduces, or terminates eligibility for the MinnesotaCare program, or services provided under the MinnesotaCare program, the commissioner must provide notification according to the laws and rules governing the medical assistance program. A MinnesotaCare program applicant or enrollee aggrieved by a determination of the commissioner has the right to appeal the determination according to section 256.045.

History: *1986 c 444; 1991 c 292 art 4 s 17; 1992 c 549 art 4 s 11,19; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72*

256L.11 PROVIDER PAYMENT.

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

Subd. 2. **Payment of certain providers.** Services provided by federally qualified health centers, rural health clinics, facilities of the Indian Health Service, and certified community behavioral health clinics shall be paid for according to the same rates and conditions applicable to the same service provided by providers that are not federally qualified health centers, rural health clinics, facilities of the Indian Health Service, or certified community behavioral health clinics. The alternative payment methodology described under section 256B.0625, subdivision 30, paragraph (l), shall not apply to services delivered under this chapter by federally qualified health centers, rural health clinics, and facilities of the Indian Health Service. The prospective payment system for certified behavioral health clinics under section 256B.0625, subdivision 5m, shall not apply to services delivered under this chapter.

Subd. 2a. MS 2018 [Repealed, 1Sp2019 c 9 art 7 s 47]

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

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

Subd. 5. [Repealed, 2013 c 108 art 1 s 68]

Subd. 6. [Repealed, 2013 c 108 art 1 s 68]

Subd. 6a. **Dental providers.** (a) Effective for dental services provided on or after January 1, 2022, payment rates to dental providers shall equal the payment rates described in section 256B.76, subdivision 2.

(b) Payments made to prepaid health plans under section 256L.12 shall reflect the payment rates described in this subdivision. The prepaid health plans under contract with the commissioner shall provide payments to dental providers that are at least equal to a rate that includes the payment rate specified in this subdivision, and if applicable to the provider, the rates described under subdivision 7.

Subd. 7. **Critical access dental providers.** (a) Effective for dental services provided to MinnesotaCare enrollees on or after July 1, 2017, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 20 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase.

(b) Managed care plans and county-based purchasing plans shall increase reimbursement to critical access dental providers by at least the amount specified in paragraph (a). If, for any coverage year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed an amount equal to any increase in rates that results from this provision. If, for any coverage year, federal approval is not received for this paragraph, the commissioner shall not implement this paragraph for subsequent coverage years.

History: *1993 c 345 art 9 s 9; 1994 c 625 art 8 s 57; 1995 c 234 art 6 s 21; 1997 c 225 art 1 s 15; 1998 c 407 art 5 s 37,47; 1999 c 159 s 106; 1Sp2001 c 9 art 2 s 66; 2002 c 379 art 1 s 113; 2006 c 282 art 16 s 13; 2007 c 147 art 5 s 31; 2009 c 79 art 5 s 67; 2009 c 173 art 1 s 38; 1Sp2010 c 1 art 16 s 34; 1Sp2011 c*

9 art 6 s 79,80; 2013 c 108 art 1 s 58,59; 2016 c 189 art 19 s 28; 1Sp2017 c 6 art 4 s 58,59; 1Sp2019 c 9 art 7 s 43; 1Sp2021 c 7 art 1 s 28,29; 2024 c 85 s 76,77

256L.12 MANAGED CARE.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) A health maintenance organization must be a nonprofit corporation organized under chapter 317A to serve as a managed care contractor under this section and section 256L.121.

Subd. 8. **Substance use disorder assessments.** The managed care plan shall be responsible for assessing the need and provision of substance use disorder services according to criteria set forth in section 245G.05.

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

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

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

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

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

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

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

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

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

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospitals admission rate compared to the hospital admission rate for calendar year 2011 as determined by the commissioner. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (f).

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

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

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

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

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

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

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

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

History: *1993 c 345 art 9 s 10; 1994 c 625 art 8 s 58-60; 1995 c 234 art 6 s 17; 1997 c 225 art 1 s 16; art 2 s 56,62; 1998 c 407 art 5 s 38; 1Sp2001 c 9 art 2 s 64; 2002 c 220 art 15 s 23; 2002 c 375 art 2 s 46; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 12 s 80-82; 2004 c 228 art 1 s 75; 1Sp2005 c 4 art 8 s 73; 2007 c 147 art 8 s 31; 2008 c 364 s 9; 1Sp2010 c 1 art 16 s 36,37; 1Sp2011 c 9 art 6 s 81; 2012 c 187 art 1 s 42; 2012 c 247 art 1 s 23; 2013 c 108 art 1 s 60; 2016 c 158 art 1 s 214; art 2 s 109,110; 2022 c 98 art 4 s 51; 2023 c 50 art 2 s 56; 2024 c 127 art 57 s 67*

256L.121 SERVICE DELIVERY.

Subdivision 1. **Competitive process.** The commissioner of human services shall establish a competitive process for entering into contracts with participating entities for the offering of standard health plans through MinnesotaCare. Coverage through standard health plans must be available to enrollees beginning January 1, 2015. Each standard health plan must cover the health services listed in and meet the requirements of section 256L.03. The competitive process must meet the requirements of section 1331 of the Affordable Care Act and be designed to ensure enrollee access to high-quality health care coverage options. The commissioner, to the extent feasible, shall seek to ensure that enrollees have a choice of coverage from more than one participating entity within a geographic area. In counties that were part of a county-based purchasing plan on January 1, 2013, the commissioner shall use the medical assistance competitive procurement process under section 256B.69, under which selection of entities is based on criteria related to provider network access, coordination of health care with other local services, alignment with local public health goals, and other factors.

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

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

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

Subd. 3. **Coordination with state-administered health programs.** The commissioner shall coordinate the administration of the MinnesotaCare program with medical assistance to maximize efficiency and improve the continuity of care. This includes, but is not limited to:

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

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

(3) complying with sections 256B.69, subdivision 3a; 256B.692, subdivision 1; and 256B.694, when contracting with MinnesotaCare participating entities;

(4) providing MinnesotaCare enrollees, to the extent possible, with the option to remain in the same health plan and provider network, if they later become eligible for medical assistance or coverage through MNsure and if, in the case of becoming eligible for medical assistance, the enrollee's MinnesotaCare health plan is also a medical assistance health plan in the enrollee's county of residence; and

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

History: *2013 c 108 art 1 s 61; 2015 c 71 art 11 s 56*

256L.13 [Repealed, 1998 c 407 art 5 s 48]

256L.14 [Repealed, 1998 c 407 art 5 s 48]

256L.15 PREMIUMS.

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

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

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

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

(1) payment by check;

(2) payment by credit card;

(3) payment by recurring automatic checking withdrawal;

(4) payment by onetime electronic transfer of funds;

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

(6) payment by using state tax refund payments.

At application or reapplication, a MinnesotaCare applicant or enrollee may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to collect funds from the applicant's or enrollee's refund for the purposes of meeting all or part of the applicant's or enrollee's MinnesotaCare premium obligation.

The applicant or enrollee may authorize the commissioner to apply for the state working family tax credit on behalf of the applicant or enrollee. The setoff due under this subdivision shall not be subject to the $10 fee under section 270A.07, subdivision 1.

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

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

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

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

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

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

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

Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
35%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$14
120%	130%	$15
130%	140%	$16
140%	150%	$25
150%	160%	$37
160%	170%	$44
170%	180%	$52
180%	190%	$61
190%	200%	$71
200%		$80

(e) Beginning January 1, 2021, the commissioner shall adjust the premium scale established under paragraph (d) to ensure that premiums do not exceed the amount that an individual would have been required to pay if the individual was enrolled in an applicable benchmark plan in accordance with the Code of Federal Regulations, title 42, section 600.505 (a)(1).

Subd. 3. MS 2010 [Repealed, 2008 c 358 art 3 s 14]

Subd. 4. [Repealed, 2010 c 200 art 1 s 21]

History: *1995 c 234 art 6 s 20; 1998 c 407 art 5 s 39; 1999 c 245 art 4 s 99-101; 2001 c 203 s 16; 1Sp2001 c 9 art 2 s 65; 2002 c 220 art 15 s 24,25; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 12 s 83-85; 2005 c 10 art 1 s 57; 1Sp2005 c 4 art 8 s 74-76; 2007 c 147 art 5 s 32-34; 2008 c 286 art 1 s 11; 2008 c 358 art 3 s 11,14; 2009 c 79 art 5 s 68,69; 2009 c 173 art 3 s 20,25; 1Sp2010 c 1 art 24 s 7; 1Sp2011 c 9 art 6 s 82; 2012 c 216 art 13 s 18; 2013 c 108 art 1 s 62,63; 2015 c 71 art 11 s 57,58; 2016 c 189 art 19 s 29; 1Sp2017 c 6 art 4 s 60; 2020 c 115 art 3 s 34; 1Sp2021 c 7 art 1 s 30*

256L.16 [Renumbered 256L.11, subd 2a]

256L.17 Subdivision 1. [Repealed, 2013 c 108 art 1 s 68]

Subd. 2. [Repealed, 2013 c 108 art 1 s 68]

Subd. 3. [Repealed, 2013 c 108 art 1 s 68]

Subd. 4. [Repealed, 2013 c 108 art 1 s 68]

Subd. 5. [Repealed, 2013 c 108 art 1 s 68]

Subd. 6. [Repealed, 2009 c 79 art 5 s 80]

Subd. 7. [Repealed, 2010 c 200 art 1 s 21]

256L.18 PENALTIES.

Whoever obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, or by the intentional withholding or concealment of a material fact, or by impersonation, or other fraudulent device:

(1) benefits under the MinnesotaCare program to which the person is not entitled; or

(2) benefits under the MinnesotaCare program greater than that to which the person is reasonably entitled;

shall be considered to have violated section 256.98, and shall be subject to both the criminal and civil penalties provided under that section.

History: *1997 c 225 art 1 s 18*

256L.22 [Repealed, 2016 c 189 art 19 s 31]

256L.24 [Repealed, 2016 c 189 art 19 s 31]

256L.26 [Repealed, 2016 c 189 art 19 s 31]

256L.28 [Repealed, 2016 c 189 art 19 s 31]