HOUSE RESEARCH

Bill Summary

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Authors: Huntley

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Analyst: Lynn Aves (articles 1, 5)
Randall Chun (articles 2, 7)
Emily Cleveland (article 6)
Danyell Punelli (articles 3, 4)

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Article 1: Licensing

Overview

This article amends statutes to permit an individual who has been disqualified from employment based on a preponderance of evidence, but has had that disqualification set aside, to have a fair hearing on the disqualification. On February 23, 2010, the Minnesota Court of Appeals issued an order providing that an individual who is disqualified from employment based on a preponderance of evidence has a due process right to a hearing to challenge the disqualification. The case is *Thompson v. Com'r*, 778 N.W.2d 401 (Minn.App. 2010).

1 **Fair hearing when disqualification is not ~~set aside~~ rescinded.** Amends § 245C.27, subd. 1, including the headnote. Strikes the term "set aside" and replaces it with "rescinded."

2 **Consolidated fair hearing.** Amends § 245C.27, subd. 2. Strikes the term "set aside" and replaces it with "rescinded."

3 **Employees of public employer.** Amends § 245C.28, subd. 3. Strikes the term "set aside" and replaces it with "rescind." Clarifies that if a disqualification is deemed conclusive under section 245C.29 then the individual may not request a contested case hearing.

4 **State agency hearings.** Amends § 256.045, subd. 3. Strikes the term "set aside" and replaces it with "rescinded."

5 **Administrative reconsideration; review panel.** Amends § 626.556, subd. 10i. Strikes the term "set aside" and replaces it with "rescinded." Strikes obsolete language.

6 **Administrative reconsideration; review panel.** Amends § 626.557, subd. 9d. Strikes the term "set aside" and replaces it with "rescinded."

Article 2: Health Care

Overview

This article contains provisions related to state health care programs administered by the Department of Human Services.

1 **Transfers.** Amends § 16A.724, subd. 2. Requires the commissioner of management and budget to transfer the following amounts from the general fund to the health care access fund: $40.467 million in FY 2011; $8.630 million in FY 2012; and $16.255 million in FY 2013. Provides that the section is effective upon federal approval of the MA expansion for adults without children.

2 **Definitions.** Amends § 144.291, subd. 2. Amends the definition of "related health care entity" in the Health Records Act to include affiliates of providers participating in a coordinated care delivery system.

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3 **Review and evaluation of studies.** Amends § 256.01, by adding subd. 30. Directs the commissioner to review all published studies, reports, and evaluation completed by DHS, and those requested by the legislature but not completed, for FY 2000 to 2010. Requires the commissioner to report for each item the legislative appropriation, and actual cost of completion, and to make recommendations as to which studies, reports, and evaluations are duplicative, unnecessary, or obsolete. Requires this review to be repeated every five fiscal years.

4 **Surcharge on HMOs and community integrated service networks.** Amends § 256.9657, subd. 3. Effective June 1, 2010, increases the health maintenance organization surcharge from 0.6 percent of total premium revenues to 2.5 percent. Also requires each county-based purchasing plan to pay a surcharge of 2.5 percent of total premium revenues effective June 1, 2010. Exempts from the surcharge increase an HMO that reports a risk-based capital level that is less than 2.5 multiplied by the authorized control level risk-based capital. Provides a June 1, 2010, effective date.

5 **Payments.** Amends § 256.969, subd. 3a. A new paragraph (i) reduces inpatient hospital payments for fee-for-service admissions by 7 percent, beginning July 1, 2010, but excludes hospitals located outside of the seven-county metropolitan area from this reduction for the period July 1, 2010, to June 30, 2011. Beginning July 1, 2011, reduces payments to hospitals located outside of the seven-county metropolitan area by 7 percent from the rate in effect on June 30, 2010. Requires payment to managed care plans to be reduced for services provided on or after January 1, 2011, to reflect this reduction.

A new paragraph (j) increases payments for MA fee-for-service admissions by 7.15 percent for the period July 1, 2010, to June 30, 2011, for hospitals located outside of the seven-county metropolitan area. States that this increase is temporary.

6 **Competitive bidding.** Amends § 256B.04, subd. 14. Allows the commissioner to purchase medical supplies using volume purchase through competitive bidding and negotiation.

7 **Adults without children.** Amends § 256B.055, by adding subd. 15. Allows MA to be paid for a person over age 21 and under age 65, who is not pregnant, and who is not otherwise eligible for MA. States that the section is effective upon federal approval and is retroactive to April 1, 2010.

8 **Income.** Amends § 256B.056, subd. 4. Sets the income standard for adults without children on MA eligible under § 256B.055, subd. 15, at 75 percent of the federal poverty guidelines. States that the section is effective upon federal approval and is retroactive to April 1, 2010.

9 **Physical therapy.** Amends § 256B.0625, subd. 8. Requires authorization by the commissioner to provide physical therapy services to a recipient beyond the following one-time service thresholds: (1) 80 units of any approved CPT code other than modalities; (2) 20 modality sessions; and (3) three evaluations or re-evaluations. Eliminates coverage for specialized maintenance therapy.

10 **Occupational therapy.** Amends § 256B.0625, subd. 8a. Requires authorization by the commissioner to provide occupational therapy services beyond the following one-time service thresholds: (1) 120 units of any combination of approved CPT codes; and (2) two

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evaluations or re-evaluations. Eliminates coverage for specialized maintenance therapy.

11 **Speech language pathology and audiology services.** Amends § 256B.0625, subd. 8b. Requires authorization by the commissioner to provide speech language pathology and audiology services beyond the following one-time service thresholds: (1) 50 treatment sessions with any combination of approved CPT codes; and (2) one evaluation. Eliminates coverage for specialized maintenance therapy.

12 **Chiropractic services.** Amends § 256B.0625, by adding subd. 8d. Limits payment for chiropractic services to one annual evaluation and 12 visits per year unless prior authorization is obtained.

13 **Dental services.** Amends § 256B.0625, subd. 9. Modifies dental coverage for nonpregnant adults by:

- allowing coverage for full-mouth radiographs once every five years;
- allowing coverage of molar root canal therapy for patients at high risk of osteonecrosis from molar extractions;
- providing coverage of relines of full dentures, repair of acrylic bases of full dentures and acrylic partial dentures, and adding two denture teeth and two wrought wire clasps per year to partial dentures;
- providing coverage of full-mouth periodontal scaling and root planning;
- covering moderate sedation, deep sedation, and general anesthesia, when provided by an oral surgeon meeting specified criteria, when medically necessary to allow the surgical management of acute oral and maxillofacial pathology and other conditions are met; and
- allowing coverage for full-mouth surveys every two years (current law provides coverage every five years).

14 **Payment rates.** Amends § 256B.0625, subd. 13e. Increases the pharmacy dispensing fee for sole-community pharmacies from $3.65 to $4.15, and defines sole-community pharmacy. Effective July 1, 2010, sets payment for the acquisition cost of a drug at average wholesale price (AWP) minus 12.5 percent or wholesale acquisition cost (WAC) plus 5.0 percent, whichever is lower. (Under current law, the payment rate is AWP minus 15 percent.) Also sets the payment rate for antihemophilic factor drugs at AWP minus 28.12 percent or WAC minus 13.76 percent, whichever is lower. (Under current law, the payment rate for these drugs is AWP minus 30 percent.) Defines AWP and WAC. Provides an effective date of July 1, 2010, or upon federal approval, whichever is later.

15 **Access to medical services.** Amends § 256B.0625, subd. 18a. Provides that MA will cover oral language interpreter services only if the interpreter used by the provider is listed in the registry or roster established by the commissioner of health under § 144.058. Provides a July 1, 2010 effective date.

16 **Medical supplies and equipment.** Amends § 256B.0625, subd. 31. Allows the commissioner to set reimbursement rates for specified categories of medical supplies at

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levels below the Medicare payment rate.

17 **Services provided in birth centers.** Amends § 256B.0625, by adding subd. 54. (a) Provides that MA covers services provided in a licensed birth center by a licensed health professional, if the service would otherwise be covered if provided in a hospital.

(b) Sets payment rates for facility services provided by a birth center at the lower of billed charges or 70 percent of the statewide average for facility payments to hospitals for uncomplicated vaginal births. If the recipient is transported from a birth center to a hospital prior to delivery, sets payments for facility services provided by the birth center at the lower of billed charges or 15 percent of the statewide average for facility payments to hospitals for uncomplicated vaginal births.

(c) Sets payments for professional services provided by licensed traditional midwives at the lower of billed charges or 65 percent of the rate paid to a physician. Prohibits billing for delivery services or postpartum care if a recipient is transported from a birth center to a hospital prior to delivery. States that services by an unlicensed traditional midwife are not covered.

(d) Directs the commissioner to apply for any necessary federal waivers to allow birth centers and birth center providers to be reimbursed.

Provides an effective date of January 1, 2011, or upon federal approval, whichever is later.

18 **Co-payments.** Amends § 256B.0631, subd. 1. Effective January 1, 2011, reduces the MA co-payment for nonemergency visits to a hospital-based emergency room from $6 to $3.50. Effective July 1, 2010, increases the enrollee per month maximum for prescription drug co-payments from $7 to $12.

19 **Collection.** Amends § 256B.0631, subd. 3. Makes a conforming change related to the increase in the monthly maximum for prescription drug co-payments. Also provides that payments to providers and managed care plans are not increased due to the reduction in the co-payment for nonemergency visits to an emergency room.

20 **Reimbursement under other state health care programs.** Amends § 256B.0644. Clarifies that the state health care program participation requirement applies under GAMC only to pharmacy providers dispensing prescription drugs under that program's criteria. Provides a June 1, 2010, effective date.

21 **Home care therapies.** Amends § 256B.0653, subd. 5. Makes a conforming change related to elimination of coverage for specialized maintenance therapy.

22 **Payment reform demonstration project for special patient populations.** Adds § 256B.0755. Requires the commissioner of human services, in consultation with the commissioner of health, to establish a payment reform demonstration project to implement and evaluate methods of reducing hospitalization, emergency room use, high cost medication and specialty services, and use of long-term care services under state health care programs. Requires the commissioner to give priority to projects that serve patients with chronic medical conditions or complex medical needs that are complicated by a physical disability, serious mental illness, or serious socioeconomic factors, and to give priority to providers who have the highest concentration of these patients. Requires proposals to be submitted by

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September 1, 2010. Requires projects to reduce the total cost of care, requires cost neutrality, and specifies other requirements and project criteria.

23 **Intensive care management program.** Adds § 256B.0757.

Subd. 1. Report. Requires the commissioner to review MA enrollment and by July 1, 2011, report to the legislature on the common characteristics and costs of enrollees age 18 and over whose annual medical costs are greater than 95 percent of all other enrollees.

Subd. 2. Intensive care management system established. Requires the commissioner to implement, by January 1, 2012, or upon federal approval, a program to provide intensive care management to MA enrollees age 18 and over served under fee-for-service, managed care, or county-based purchasing, whose annual MA costs are in the top 5 percent of all MA enrollees. Requires the program to reduce MA costs for these enrollees by at least 20 percent on average, improve quality of care through care coordination, and provide financial incentives for providers to deliver care efficiently. States that the commissioner may require enrollees to participate in the program, and may reassign enrollees from existing managed care and county-based purchasing plans to plans participating in the program. Requires the commissioner to seek all necessary federal approvals and waivers to implement the program.

Subd. 3. Request for proposals. Requires the commissioner to request proposals, by September 1, 2011, or upon federal approval, from health care providers, managed care plans, and county-based purchasing plans to provide intensive care management services. Specifies criteria for proposals.

Provides an immediate effective date.

24 **Additional portion of nonfederal share.** Amends § 256B.19, subd. 1c. Reduces Hennepin County IGT monthly payments for the period October 1, 2008, to December 30, 2010, from $566,000 to $434,688, to comply with federal requirements prohibiting increases in the percentage of MA costs paid for by local units of government. Extends this lower payment amount through June 30, 2011, if the federal government extends the enhanced federal medical assistance percentage (FMAP) through that date. Also makes changes in a provision dealing with payment to Metropolitan Health Plan, to reflect changing federal matching rates.

25 **Payment rate modification.** Amends § 256B.69, by adding subdivision 5k. For services provided on or after August 1, 2010, increases managed care and county-based purchasing plan payments under MA and under MinnesotaCare for families and children by 2.0 percent. Provides an August 1, 2010, effective date.

26 **Payment reduction.** Amends § 256B.69, by adding subd. 5l. Reduces MA, GAMC, and MinnesotaCare payments to managed care plans by 1 percent from current rates for services provided on or after January 1, 2011. Excludes payments for nursing home services, home and community-based waivers, home care services, payments to demonstration projects serving persons with disabilities, and mental health services added as covered benefits after December 31, 2007.

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27 **Information for persons with limited English-language proficiency.** Amends § 256B.69, subd. 27. Eliminates a cross-reference to a GAMC provision that was repealed. Provides a retroactive effective date of April 1, 2010.

28 **In general.** Amends § 256B.692, subd. 1. Removes references to the prepaid general assistance medical care program. Provides a retroactive effective date of April 1, 2010.

29 **Physician reimbursement.** Amends § 256B.76, subd. 1a. The amendment to paragraph (c) specifies that the rate reduction for physician and professional services does not apply to physical therapy, occupational therapy, and speech pathology and related services, effective July 1, 2010.

A new paragraph (d) reduces payments for physician and professional services by 3 percent, for services provided on or after July 1, 2010. Exempts certain primary care providers and services. Requires payments to managed care and county-based purchasing plans to reflect this reduction, effective October 1, 2010.

A new paragraph (e) increases payment rates, effective June 1, 2010, for physician and professional services delivered in clinics owned by a nonprofit HMO and recognized as level three patient centered medical homes, by 15 percent. Also requires payments to managed care and county-based purchasing plans to reflect this payment increase, beginning October 1, 2010.

30 **Critical access dental providers.** Amends § 256B.76, subd. 4. Modifies the criteria the commissioner must use to determine which dentists and dental clinics are critical access dental providers. Requires the commissioner to pay critical access dental provider payments to a dentist or dental clinic if any of the following apply:

(1) at least 40 percent of patient encounters are with patients who are uninsured or covered by MA, GAMC, or MinnesotaCare;

(2) the dental clinic or dental group is owned and operated by a nonprofit operation with more than 10,000 patient encounters per year with patients who are uninsured or covered by MA, GAMC, or MinnesotaCare; or

(3) the dental clinic is associated with an oral health or dental education program operated by the University of Minnesota or an institution within the Minnesota State Colleges and Universities system.

In making a designation, also requires the commissioner to review:

(1) whether the level of services provided by the dentist or clinic is critical to ensuring a maximum travel distance or travel time to services that is the lesser of 60 miles or 60 minutes;

(2) whether the provider has completed the application by the due date and provided correct information;

(3) whether the dentist or clinic meets the quality and continuity of care criteria recommended by the dental services advisory committee and adopted by the department; and

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(4) whether the dentist or clinic serves people in all Minnesota health care programs.

States that the section is effective January 1, 2011.

31 **Designation and termination of critical access dental providers.** Amends § 256B.76 by adding subd. 4a. (a) Provides that the commissioner may review and not designate an individual dentist or dental clinic as a critical access provider when the dentist or clinic:

(1) has been subject to a corrective or disciplinary action by the Board of Dentistry related to fraud or direct patient care; or

(2) has been subject, within the past three years, to postinvestigation action by the commissioner of human services or issuance of a warning;

(b) Allows the commissioner to terminate a critical access designation of an individual dentist or clinic if the dentist or clinic:

(1) becomes subject to disciplinary or corrective action by the Board of Dentistry related to fraud or direct patient care;

(2) becomes subject to postinvestigation action by the commissioner or issuance of a warning;

(3) does not meet the quality and continuity of care criteria recommended by the dental services advisory committee and adopted by the department; or

(4) does not serve enrollees in all Minnesota health care programs.

(c) Provides that any termination is effective on the date of notification of the postinvestigative action, disciplinary or corrective action, or a determination of not meeting quality and continuity of care criteria.

Allows the commissioner to review post-investigative actions taken by a health plan under contract to provide dental services to Minnesota health care program enrollees, and incorporate these findings to determine if a provider will be designated or terminated.

(d) Allows providers who have been terminated or not designated to appeal only through the contested hearing process and specifies appeal requirements.

(e) Allows the commissioner to make an exception to paragraphs (a) and (b) in cases of onetime events not directly related to patient care or that will not affect direct patient care to Minnesota health care program enrollees.

Provides an immediate effective date.

32 **Reimbursement for basic care services.** Amends § 256B.766. States that the basic care reduction applies to physical therapy, occupational therapy, and speech language pathology and related services, effective July 1, 2010. Requires the commissioner to classify these services as basic care services, effective July 1, 2010.

33 **Medicare payment limit.** Adds § 256B.767. Effective July 1, 2010, provides that fee-for-service payments for physician and professional services and basic care services shall not

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exceed the applicable Medicare payment rate.

34 **Fee-for-service payment increase.** Adds § 256B.767. Requires the commissioner to increase fee-for-service payment rates, for services provided on or after January 1, 2011, by 7 percent for physician and professional services, and for basic care services.

35 **General assistance medical care; eligibility.** Amends § 256D.03, subd. 3. The amendment to paragraph (b) provides that GAMC coverage of pharmacy services includes medication therapy management.

A new paragraph (d) specifies that for the period April 1, 2010, to May 31, 2010, GAMC covered services are those specified in subdivision 4 (services covered under the old GAMC program) rather than those services covered under the modified GAMC program. Provides a retroactive effective date of April 1, 2010.

36 **Financial management.** Amends § 256L.02, subd. 3. Modifies the MinnesotaCare financial management criteria, by eliminating the requirements that premium subsidies for families and children be reduced and that applicants be required to be uninsured for at least six-months. Also provides that the remaining financial management measures—stopping enrollment of adults without children and eliminating coverage for adults without children already enrolled, shall not be implemented before July 1, 2014. If these measures are not sufficient to ensure that MinnesotaCare expenditures remain within the limits of revenues, requires the commissioner to notify specified legislative chairs and the legislative commission on health care access, and to present recommendations for limiting expenditures to the estimated amount of revenue. Provides that the section is effective upon federal approval of the MA expansion for adults without children.

37 **Inpatient hospital services.** Amends § 256L.03, subd. 3. Provides a cross-reference to the provision of MinnesotaCare supplemental hospital coverage. Provides an effective date of January 1, 2011, or upon federal approval, whichever is later.

38 **Supplemental hospital coverage.** Amends § 256L.03, by adding subd. 3b. (a) Effective January 1, 2011, or upon federal approval, whichever is later, requires the commissioner to offer all MinnesotaCare applicants, and all enrollees during open enrollment periods, the opportunity to purchase at full cost supplemental hospital coverage to cover inpatient hospital expenses in excess of the $10,000 annual inpatient hospital limit. Allows premiums for coverage to vary only for age and requires premiums to be collected by the commissioner using the procedures that apply to payment of regular sliding scale premiums.

(b) Requires the commissioner to notify all persons submitting applications of this option, and to provide persons enrolled in MinnesotaCare on the effective date of this subdivision the opportunity to purchase the supplemental coverage during an initial open enrollment period. Requires annual open enrollment periods during the month of November, with coverage taking effect January 1.

39 **Co-payments and coinsurance.** Amends § 256L.03, subd. 5. The amendment to paragraph (a) reduces the MinnesotaCare co-payment for nonemergency visits to a hospital-based emergency room from $6 to $3.50, effective January 1, 2011.

The amendment to paragraph (e) makes a conforming change related to MinnesotaCare

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supplemental hospital coverage.

A new paragraph (g) states that provider and managed care plan payments shall not be increased due to the reduction in the co-payment.

States that the amendment to paragraph (e) is effective January 1, 2011, or upon federal approval, whichever is later.

40 **Disclosure statement for inpatient hospital limit.** Amends § 256L.05, by adding subd. 6. Requires the commissioner to develop, and include with MinnesotaCare application and renewal materials, a disclosure statement related to the $10,000 annual inpatient hospital limit (this limit applies to all adults without children and to parents with incomes greater than 215 percent of FPG).

41 **Firefighters; volunteer ambulance attendants.** Amends § 256L.07, by adding subd. 9. (a) Defines a "qualified individual" as: (1) a volunteer firefighter with a department, who has passed the probationary period; and (2) a volunteer ambulance attendant.

(b) States that a qualified individual, who documents to the satisfaction of the commissioner status as a qualified individual, by completing and submitting a one-page form developed by the commissioner, is eligible for MinnesotaCare without meeting other eligibility requirements, but must pay premiums equal to the average expected capitation rate for adults with no children. Specifies that the benefit set is that provided to adults with no children.

42 **Medical assistance rate to be used.** Amends § 256L.11, subd. 1. Effective July 1, 2010, reduces MinnesotaCare payment rates for physician and professional services by 3 percent, for those providers not otherwise exempted under § 256B.76, subdivision 1, paragraph (c). Requires payments to managed care and county-based purchasing plans to be reduced effective October 1, 2010, to reflect this reduction.

43 **Eligibility for other state programs.** Amends § 256L.12, subd. 5. Removes references to prepaid GAMC. Provides a retroactive effective date of April 1, 2010.

44 **Co-payments and benefit limits.** Amends § 256L.12, subd. 6. Makes a conforming change related to MinnesotaCare supplemental hospital coverage. Provides an effective date of January 1, 2011, or upon federal approval, whichever is later.

45 **Rate setting; performance withholds.** Amends § 256L.12, subd. 9. For services provided on or after January 1, 2011, requires the commissioner to withhold an additional 3 percent of MinnesotaCare managed care payments. Requires the withheld funds to be returned between July 1 and July 31, 2012. Provides that return of this withhold is not subject to meeting performance targets. Allows a plan to include as admitted assets any amount withheld under the section (current law applies this provision to one paragraph within the section).

46 **Expiration.** Amends Laws 2009, chapter 79, article 5, section 78, subdivision 5. Extends the expiration date for the state premium subsidy program for COBRA continuation coverage from December 31, 2010, to June 30, 2011, and extends the exemption from the four-month uninsured requirement to December 31, 2011, to reflect the extension of the federal premium subsidy program for continuation coverage.

47 **Coordinated care delivery systems.** Amends Laws 2010, chapter 200, article 1, section 12,

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subdivision 6. The amendment to paragraph (b) provides that coordinated care delivery system contracts are in effect from June 1, 2010, to December 31, 2010, or upon the effective date of the MA expansion for adults without children, whichever is later. (Under current law, contracts are in effect for 12-month periods.)

The amendment to paragraph (c) allows applicants or recipients to choose among systems that provide services within 25 miles of the individual's community of residence, and limits assignment by the commissioner to systems that meet this distance criterion.

A new paragraph (k) clarifies payment methods and financial responsibility in cases of recipient transfers from a hospital that is not participating in a coordinated care delivery system to a hospital that is participating in a coordinated care delivery system.

48 **Payments; rate setting for the hospital coordinated delivery system.** Amends Laws 2010, chapter 200, article 1, section 12, subdivision 7. Specifies the method for paying the June quarterly payment to hospitals participating in the GAMC coordinated care delivery system.

49 **Temporary uncompensated care pool.** Amends Laws 2010, chapter 200, article 1, section 12, subdivision 8. The amendment to paragraph (a) allows ambulance services to receive uncompensated care pool payments if a call or transfer originates from a location more than 25 miles from the health care facility that receives the enrollee.

The amendment to paragraph (b) extends the sunset of the pool from November 30, 2010, until December 31, 2010, or until MA coverage is expanded to include adults without children, whichever is later.

50 **Effective date.** Amends the effective date section of Laws 2010, chapter 200, article 1, section 12, to provide that subdivision 4 of that section (covered benefits under the modified GAMC program) is effective June 1, 2010, rather than April 1, 2010. Provides a retroactive effective date of April 1, 2010.

51 **Retroactive coverage.** Amends Laws 2010, chapter 200, article 1, section 16 (retroactive MinnesotaCare coverage for GAMC recipients at renewal), by providing an effective date for that section of June 1, 2010.

52 **Repealer.** Amends Laws 2010, chapter 200, article 1, section 21. Changes the effective date for the repeal of § 256D.03, subdivision 4 (covered benefits under the old GAMC program) from April 1 to June 1, 2010. Provides a retroactive effective date of April 1, 2010.

53 **Special revenue fund transfers.** Amends Laws 2010, chapter 200, article 2, section 2, subd. 1. Requires transfers for FY 2010 and FY 2011 from the special revenue fund to the general fund. Provides an immediate effective date.

54 **Compulsive gambling appropriation.** Amends Laws 2010, chapter 200, article 2, section 2, subd. 8. Clarifies that the lottery prize fund appropriation for compulsive gambling administration is reduced by specified amounts, and that these are onetime reductions. Provides an immediate effective date.

55 **Early expansion.** Requires all costs related to the early expansion of MA eligibility to include adults without children to be paid from the health care access fund. States that the

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section is effective upon federal approval and is retroactive to April 1, 2010.

56 **Fiscal and actuarial analysis.** Requires the commissioner of human services to offer a request for proposals and accept bids for a complete fiscal and actuarial analysis of 2010 H.F. 135/S.F. 118 (Minnesota health plan bill). Requires the commissioner to report this analysis to the legislative chairs of the health and human services policy and finance divisions by December 15, 2010.

57 **Prepaid health plans.** Requires the commissioner of human services, in negotiating managed care contract rates for services provided on or after January 1, 2011, to take into consideration and reflect in the rates the anticipated MA savings due to extending MA coverage to services provided in licensed birth centers, the anticipated use of these services, and reduced MA costs associated with the use of birth centers for normal, low-risk deliveries.

58 **Repealer; transfer.** Repeals provisions of law related to the GAMC program, effective 30 days after federal approval of the MA expansion for adults without children, or January 1, 2011, whichever is later. Also transfers remaining unspent appropriations for GAMC to the health care access fund.

Article 3: Continuing Care

Overview

This article makes changes to TEFRA parental fees, MA-EPD, PACE, and includes rate reductions for nursing facilities, ICF/DD facilities, and certain continuing care providers.

1 **Contribution amount.** Amends § 252.27, subd. 2a. Modifies the parental fees for children receiving MA through the TEFRA option.

2 **Employed persons with disabilities.** Amends § 256B.057, subd. 9. Clarifies that persons participating in MA-EPD may have excess earnings or assets. Removes an obsolete date. Increases MA-EPD premiums. Requires the commissioner to notify enrollees annually beginning at least 24 months before a person's 65th birthday of the MA rules affecting income, assets, and treatment of a spouse's income and assets that will be applied upon reaching age 65. Makes this section effective January 1, 2011.

3 **Elderly waiver cost limits.** Amends § 256B.0915, subd. 3a. Eliminates the automatic adjustment to the EW monthly case mix caps when there is an increase in the average statewide nursing facility payment rates.

4 **Cost limits for elderly waiver applicants who reside in a nursing facility.** Amends § 256B.0915, subd. 3b. Eliminates the automatic adjustment to the EW monthly case mix caps when there is an increase in the average statewide nursing facility payment rates. Modifies terminology.

5 **Nursing facility rate reductions effective July 1, 2010.** Amends § 256B.441, by adding subd. 60. Paragraph (a) reduces nursing facility operating payment rates by 1.5 percent of the operating payment rate in effect on June 30, 2010, for the rate period July 1, 2010, through

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June 30, 2011.

Paragraph (b) restores nursing facility operating payment rates to the operating payment rate in effect on June 30, 2010, effective July 1, 2011.

6 **ICF/MR rate reductions effective July 1, 2010.** Amends § 256B.5012, by adding subd. 9. Reduces ICF/DD operating payment rates by 1.5 percent of the operating payment rate in effect on June 30, 2010, for the rate period July 1, 2010, through June 30, 2011. Restores ICF/DD operating payment rates to the operating payment rate in effect on June 30, 2010, effective July 1, 2011. Specifies how the commissioner shall implement the rate reduction.

7 **Alternative services; elderly and disabled persons.** Amends § 256B.69, subd. 23. Removes obsolete language. Removes language requiring grant amounts received for this purpose to be deposited in the special revenue fund and appropriated to the commissioner to be used for actuarial and administrative costs.

8 **COLA compensation requirements.** Effective July 1, 2010, removes the requirement that certain providers who received rate increases in state fiscal years 2008 and 2009 continue or retain employee compensation or wage-related increases that were required in law as a condition of receiving the rate increase.

9 **Provider rate and grant reductions.** For the rate period July 1, 2010, through June 30, 2011, reduces grants, allocations, reimbursements, or rate limits, as applicable, by 1.5 percent from the applicable amount on June 30, 2010, for a variety of continuing care programs and providers. Effective July 1, 2011, restores grants, allocations, reimbursements, or rate limits, as applicable, to the applicable amount on June 30, 2010, for a variety of continuing care programs and providers.

10 **Case management reform.** Requires the commissioner of human services to provide specific recommendations and language for proposed legislation to reform case management by February 1, 2011. Requires the commissioner to consider the recommendations in the 2007 Redesigning Case Management Services for Persons with Disabilities report and to consult with certain stakeholder groups in developing the recommendations. Makes this section effective the day following final enactment.

11 **Commissioner to seek federal match.** Requires the commissioner to seek federal financial participation for eligible activity related to fiscal year 2010 and 2011 grants to Advocating Change Together to establish a statewide self-advocacy network for persons with developmental disabilities and for eligible activities under any future grants to the organization. Requires the commissioner to report to designated legislative committees by December 15, 2010, with the results of the application for federal matching funds

Article 4: Children and Family Services

Overview

This article modifies food stamp income and asset limits and modifies the MFIP program.

1 **Asset limitations for food stamp households.** Amends § 256D.0515. Modifies income and asset limits for food stamp households.

2 **Other property limitations.** Amends § 256J.20, subd. 3. Modifies the MFIP asset limit related to the loan value of a vehicle. Makes this section effective October 1, 2010.

3 **MFIP exit level.** Amends § 256J.24, subd. 10. Reduces the MFIP maximum income eligibility level from 115 percent of the federal poverty guidelines to 110 percent of the federal poverty guidelines. Makes technical changes related to the timing of income eligibility level adjustments. Makes this section effective October 1, 2010.

4 **Rental subsidies; unearned income.** Amends § 256J.37, subd. 3a. Increases the amount of rental subsidies that must be counted as unearned income when determining the cash portion of the MFIP grant. Makes this section effective October 1, 2010.

Article 5: Miscellaneous

Overview

This article addresses health care coverage for cancer chemotherapy treatment, autism spectrum disorders, private duty nursing services, and TRICARE participants. It creates an Office of Health Care Inspector General, and transfers responsibility for fiscal notes from the commissioner of human services to a new division in the Office of the Legislative Auditor. Amendments to the chemical dependency treatment statutes increase the percent of county match in order to eliminate the county maintenance of effort for chemical dependency treatment.

1 **Staff; compensation.** Amends § 3.971, subd. 2. Instructs the legislative auditor to establish a Legislative Budget Office Division to prepare fiscal notes for any bill with a fiscal impact on the Department of Human Services. Provides a July 1, 2011, effective date.

2 **Fiscal notes; Department of Human Services.** Amends § 3.98, by adding subd. 5. Paragraph (a) transfers the responsibility to prepare fiscal notes from the Department of Human Services to the legislative auditor's office.

Paragraph (b) requires the Legislative Budget Office Division to prepare fiscal notes for any bills that increase or decrease spending at the Department of Human Services. Permits the commissioner of human services to include a statement in the fiscal notes.

3 **Cancer chemotherapy treatment coverage.** Creates § 62A.3075. (a) Prohibits health plan companies (insurance companies, HMOs, Blue Cross, etc.) from charging patients treated with oral cancer chemotherapy drugs higher copays and other enrollee cost-sharing than charged to patients treated with infused or injected cancer chemotherapy drugs. (Some health plan companies have what is often called a "fourth tier" of higher out-of-pockets costs that

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includes those oral drugs.)

(b) Prohibits a health plan company from complying with the "equal cost-sharing" requirement of paragraph (a) by increasing the cost-sharing for the infused or injected cancer chemotherapy drugs.

(c) Provides that this section does not prohibit a health plan company from requiring prior authorization or other utilization controls (other than differential enrollee cost-sharing) in approving coverage for chemotherapy.

Effective date: Paragraphs (a) and (c) are effective for coverage issued or renewed on or after August 1, 2010. Paragraph (b) is effective the day following final enactment.

4 Coverage for autism spectrum disorders. Creates § 62A.3094.

Subd. 1. Definitions. Defines the terms "autism spectrum disorder," "board certified behavior analyst," "evidence-based," "health plan," "manualized approach," "medical necessity or medically necessary care," "mental health professional," "qualified mental health behavioral aide," "qualified mental health practitioner," and "statistically superior outcomes."

Subd. 2. Coverage required. (a) Requires health plans to cover autism spectrum disorders. Lists some services that would be included in that requirement.

(b) Requires the health plan to provide coverage for diagnosis, evaluation, assessment, and medically necessary evidence-based care of autism spectrum disorders.

(c) Requires health plans to provide coverage for treatment in accordance with an individual treatment plan and that is evidence-based.

(d) Lists the best-practice standards that must be met for early intensive behavior therapies.

(e) Requires providers to work with the commissioner to implement evidence-based practices.

(f) Prohibits health plans from terminating or restricting an individual's insurance coverage due to the individual having an autism spectrum disorder.

(g) Prohibits health plans from requiring an updated treatment plan more often than every six months, unless the health plan and treating provider agree to a more frequent schedule for updates.

Subd. 3. Supervision, delegation of duties, and observation of qualified mental health practitioner, board certified behavior analyst, or mental health behavioral aide. Permits a mental health professional to utilize the services of the above listed individuals to provide services to patients who have autism spectrum disorder if the mental health professional maintains clinical supervision and accepts responsibility for their actions. Requires these providers to document their activities in written progress notes.

Subd. 4. State health care programs. Requires state health plans and the state

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employee group insurance plan to maintain their current level of service for treatment of autism spectrum disorder. Instructs the department to monitor services and provide a report whether there are gaps in the level of services between the state plans and the state employee group insurance plan and private health plans. Instructs the commissioner to increase rates to prepaid health plans if there is an increase in coverage for autism spectrum disorders resulting from this section.

Subd. 5. No effect on other law. Provides that nothing in this section limits the existing mental health parity law requiring insurers to cover mental health on the same basis as other illnesses.

Effective date: Makes the law effective August 1, 2010, and applies to coverage issued or renewed on or after that date. (This means for instance that an insurance policy renewed on July 1, 2010, would have to comply at its next annual renewal.)

5 **Provider participation in TRICARE.** Creates § 62J.27.

Subd. 1. Participation required. Requires a vendor of medical care who is a provider or contractor for health insurance plans for state employees, public employees, employees of local statutory or home rule charter city, county, and school districts, the workers' compensation program, and Minnesota Comprehensive Health Association plans to also participate as a provider or contractor in the federal TRICARE program.

Subd. 2. Participation defined; exemption. States that under this section participation in TRICARE means accepting new TRICARE patients. Provides an exemption if the provider is no longer accepting new patients under any of the programs listed in subdivision 1.

Subd. 3. Agency duties. Requires the commissioner of health to obtain a list of TRICARE providers and contractors and provide this list to the commissioners of management and budget, labor and industry, and commerce each quarter. Instructs the commissioners to take steps to exclude providers under their jurisdiction who do not participate in TRICARE and are not exempt under subdivision 2.

6 **Coverage of private duty nursing services.** Adds § 62Q.545. Requires a health plan to cover private duty nursing services when an inpatient hospital stay would otherwise be required. Allows a period of private duty nursing services to be subject to the same cost-sharing as an inpatient hospital stay. Provides that the section is effective July 1, 2010, and applies to health plans offered, sold, issued, or renewed on or after that date.

7 **American Indian.** Amends § 254B.01, subd. 2. Makes a technical change to conform with amendments to the chemical dependency treatment fund.

8 **Chemical dependency treatment allocation.** Amends § 254B.02, subd. 1. Strikes the formula for the chemical dependency treatment fund allocation.

9 **Administrative adjustment.** Amends § 254B.02, subd. 5. Adjusts the administrative payment to local agencies.

10 **Division of costs.** Amends § 254B.03, subd. 4. Increases the county match for chemical

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dependency treatment services from 15 percent to 16.14 percent. This increase is projected to offset the loss of funds that will occur as a result of the elimination of the maintenance of effort.

11 **Division of costs for medical assistance services.** Amends 254B.03, by creating subdivision 4a. Ensures the county match is in compliance with the federal health care reform legislation.

12 **Regional treatment centers.** Amends § 254B.05, subd. 4. Makes a technical change striking the reference to county allocations.

13 **Allocation of collections.** Amends § 254B.06, subd. 2. Strikes references to county maintenance of effort requirements.

14 **Payments to improve services to American Indians.** Amends § 254B.09, subd. 8. Clarifies that the commissioner may set rates according to the American Indian Health Improvement Act for chemical dependency services to American Indians.

15 **Office of Health Care Inspector General.** Amends § 256.01, by adding subd. 30. Paragraph (a) requires the commissioner to create within the Department of Human Services an Office of Health Care Inspector General to enhance antifraud activities and to protect the integrity of the state health care programs. Requires the office to periodically report to the commissioner and the legislature program and management problems and recommendations to correct them.

Paragraph (b) lists the duties of the Office of Health Care Inspector General.

Beginning July 1, 2011, paragraph (c) requires the commissioner, in consultation with the Office of Health Care Inspector General, to annually report to the legislature and the governor new results from two ongoing federal Medicaid audits. Requires the commissioner to present a plan to the legislature and the governor for corrective actions and the reduction of error rates under certain circumstances.

16 **Appropriation.** Transfers an unspecified amount or an amount equal to 90 percent of the administrative funds spent by the commissioner of human services in preparing fiscal notes during the 2009 fiscal year to the Office of the Legislative Auditor for preparation of fiscal notes. This appropriation is for the fiscal year beginning July 1, 2011.

17 **Repealer.** Repeals sections 254B.02, subdivision 2, 3, and 4; and 254B.09, subdivisions 4, 5, and 7. These repealed subdivisions all relate to calculation of the county maintenance of effort.

18 **Effective date.** Provides that sections 7 to 14 and 17 are effective for claims paid on or after July 1, 2010.

Article 6: Department of Health

1 **Consistent administrative expenses and investment income reporting.** Amends § 62D.08, by adding subd. 7. (a) Requires HMOs and county-based purchasers to directly allocate administrative expenses to specific lines of business or products when this

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information is available. Expenses that cannot be directly allocated must be allocated based on methods recommended by the Advisory Group on Administrative expenses. Requires HMOs to submit this information, including administrative expenses for dental services, using the reporting template provided by the commissioner of health.

(b) Requires HMOs and county-based purchasers to allocate investment income based on cumulative net income over time by business line or product, and submit this information, including investment income for dental services, using the reporting template provided by the commissioner of health.

Provides a January 1, 2012 effective date.

2 **Advisory group on administrative expenses.** Adds § 62D.31.

Subd. 1. Establishment. Establishes the Advisory Group on Administrative Expenses to develop detailed standards and procedures for examining the reasonableness of administrative expenses by individual publicly funded programs.

Subd. 2. Membership. States that membership of the group is to be comprised of: the commissioners of health, human services, and commerce, or their designees; and representatives of HMOs and county-based purchasers appointed by the commissioner of health.

Subd. 3. Administration. Requires the commissioner of health to convene the first meeting of the advisory group and provide administrative support and staff. Allows the commissioner to contract with a consultant.

Subd. 4. Recommendations. Requires the advisory group to report recommendations to the commissioner of health and the legislature by July 1, 2011.

Subd. 5. Expiration. States that this section expires June 30, 2012.

3 **Definitions.** Amends § 62J.495, subd. 1a. Makes conforming change to the definition of "interoperable electronic health record."

4 **Interoperable electronic health record requirements.** Amends § 62J.495, subd. 3. Adds to the list of requirements for implementing interoperable electronic health records systems by requiring the systems be connected to a state-certified health information organization.

5 **State agency information system.** Amends § 62J.495 by adding subd. 6. Specifies that development of state agency information systems is subject to the requirements the Office of Enterprise Technology under Minnesota Statutes, chapter 16E.

6 **Health information exchange.** Adds § 62J.498. Gives the commissioner of health authority to regulate health information exchange in the state.

Subd. 1. Definitions. Defines key terms related to health information exchange systems.

Subd. 2. Health information exchange oversight. Requires the commissioner of health to protect the public interest in matters related to health information exchange and

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specifies duties of the commissioner in this capacity.

7 **Certificate of authority to provide health information exchange services.** Adds § 62J.4981. Requires organizations to obtain a certificate of authority from the commissioner of health in order to operate as a health data intermediary or a health information organization.

Subd. 1. Authority to require organizations to apply. Requires any entity providing health information exchange services to apply for a certificate of authority through the commissioner of health.

Subd. 2. Certificate of authority for health data intermediaries. Requires health data intermediaries to register with the state. Prohibits operation of a health data intermediary without a certificate of authority from the state or an application under active consideration. Establishes minimum criteria for the commissioner to consider in issuing a certificate of authority.

Subd. 3. Certificate of authority for health information organizations. Requires health information organizations to obtain a certificate of authority from the commissioner of health. Establishes minimum criteria for the commissioner to consider in issuing a certificate of authority. Provides requirements for health information organizations, including, but not limited to, connecting to the Nationwide Health Information Network; annually submitting strategic and operational plans for review by the oversight board; and annually submitting a rate plan specifying fee structures.

Subd. 4. Application for certificate of authority for health information exchange service providers. Requires applications to be in a format specified by the commissioner and provides information that must be included in the applications.

Subd. 5. Reciprocal agreements between health information exchange entities. Regulates reciprocal agreements between health information organizations and health data intermediaries and requires that these agreements include fair and equitable models related to fees.

Subd. 6. State participation in health information exchange. Requires state agencies that connect with a health information exchange service provider for certain purposes to ensure the provider has reciprocal agreements required under this section.

8 **Enforcement authority; compliance.** Adds § 62J.4982.

Subd. 1. Penalties and enforcement. Permits the commissioner of health to issue an administrative penalty of up to $25,000 for each violation of statute or rule related to health information exchange services. Provides factors to consider in assessing the penalty. Requires the commissioner to give notice to suspected violators and provides for an informal investigation process.

Subd. 2. Suspension or revocation of certificates of authority. Provides circumstances under which the commissioner may suspend or revoke a certificate of authority. Prohibits a health information exchange service provider from enrolling participants or engaging in advertising while under a suspended certificate, and

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prohibits a health information exchange service provider from conducting any business as such if its certificate is revoked.

Subd. 3. Denial, suspension, and revocation; administrative procedures. Requires the commissioner to notify the health information exchange service provider in writing for denial, suspension, or revocation of a certificate of authority. Provides for a hearing process before the commissioner.

Subd. 4. Coordination. Requires the commissioner to seek advice from the Minnesota e-Health Advisory Committee when implementing Minnesota Statutes §§ 62J.498 to 62J.4982. Requires a report to the governor and the legislature regarding the status of health information exchange in Minnesota by January 1, 2011.

Subd. 5. Fees and monetary penalties. Provides a fee schedule to which health information exchange service providers are subject and states that penalties imposed under this subdivision are appropriated to the commissioner for purposes of Minnesota Statutes §§ 62J.498 to 62J.4982.

9 **Designation.** Amends § 62Q.19, subdivision 1. Adds licensed birth centers to the list of essential community provider designations.

10 **Birth record surcharge.** Imposes a nonrefundable surcharge of $10 for each certified birth record. Provides that this amount shall be deposited into the general fund for the Minnesota Birth Defects Information System.

11 **Birth Centers.** Adds § 144.615. Establishes state licensure for birth centers.

Subd. 1. Definition. Defines "birth center;" "CABC;" and "low-risk pregnancy" for purposes of this section.

Subd. 2. License required. Requires birth centers to be licensed beginning January 1, 2011, in order to operate in the state.

Subd. 3. Temporary license. Provides a process for issuing a temporary license that would be valid for a six-month period while a birth center awaits accreditation.

Subd. 4. Application. Requires that the license application and fee be submitted to the commissioner of health on a form provided by the commissioner and specifies information that it must contain.

Subd. 5. Suspension, revocation, and refusal to renew. Permits the commissioner to refuse to grant or renew, or to suspend or revoke a license to operate a birth center on the same grounds as such action may be taken against a hospital under § 144.55, subd. 6.

Subd. 6. Standards for licensure. Requires that a birth center be accredited by the Commission for the Accreditation of Birthing Centers (CABC) and have procedures in place for specifying patient risk status in order to obtain a state license. Requires birth centers to provide the commissioner, upon request, with any documentation submitted to the CABC during the accreditation process.

Subd. 7. Limitations of services. Limits procedures that may be performed at a

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birth center: surgical procedures must be limited to those done during an uncomplicated birth; abortions must not be administered; and general and regional anesthesia must not be administered.

Subd. 8. Fees. Imposes a biennial licensing fee of $365 and a $365 fee for a temporary license. Requires that fees be collected and deposited according to the same provisions has fees are collected for hospitals.

Subd. 9. Renewal. Requires renewal of a birth center license every two years, except that a temporary license expires after six months and may be renewed for one additional six-month period.

Subd. 10. Records. Subjects records maintained at birth centers to the Minnesota Health Records Act.

Subd. 11. Report. Requires the commissioner of health, with the commissioner of human services and representatives of the licensed birth centers, to evaluate the quality of care and outcomes of services provided in birth centers. Requires a report to the legislature by January 15, 2014.

12 **Definitions.** Amends § 144.651, subd. 2. Modifies the definition of "patient" for purposes of the Health Care Bill of Rights by including a person who receives care at a licensed birth center.

13 **Blood lead level guidelines.** Amends § 144.9504 by adding subd. 12. (a) Requires the commissioner to revise clinical and case management guidelines by January 1, 2011. Specifies that these guidelines must include recommendations for protective action and follow-up services for child blood lead levels that exceed 5 µg/dL. Requires the new guidelines to be implemented to the extent possible with available resources.

(b) Requires the commissioner of health to consult with certain entities and organizations when revising the guidelines for blood lead levels greater than 5 µg/dL.

14 **Health facility.** Amends § 144A.51, subd. 5. Modifies the definition of "health facility" for purposes of oversight of the Office of Health Facility Complaints by including birth centers.

15 **Comprehensive advanced life support.** Amends § 144E.37. Makes conforming change to sec. 18.

16 **Health plan and county administrative cost reduction; reporting requirements.** Permits health plans and county-based purchasers to complete an inventory of data collection and reporting requirements and submit the list to the commissioners of health and human services. Permits that the report to the commissioners may include information on administrative time and expense attributed to fulfilling reporting requirements. Requires the commissioners, upon receipt of such a report, to submit to the legislature recommendations as to whether action should be taken to streamline reporting requirements.

17 **Application process for health information exchange.** Requires the commissioner of health, when applying for additional federal funds to support a state health information exchange, to ensure applications are made through an open process that gives service providers equal opportunity to receive funds.

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18 **Transfer.** Transfers the powers and duties of the Emergency Medical Services Regulatory Board (EMSRB) with respect to the comprehensive advanced life-support educational program, under current Minnesota Statutes § 144E.37, to the commissioner of health, effective July 1, 2010.

19 **Revisor's instruction.** Provides an instruction to the Revisor to move the comprehensive advanced life-support educational program's statutory reference to a Department of Health chapter, Minnesota Statutes, chapter 144.

Article 7: Health Care Reform

Overview

This article contains provisions related to the implementation of federal health care reform.

1 **Relationship to temporary federal risk pool.**

Subd. 1. Definitions. Defines "the association" as the Minnesota Comprehensive Health Association ("MCHA"), which is Minnesota's high-risk health insurance pool for people who cannot get coverage in the regular private market due to preexisting health conditions. Defines "the federal law" as the section of the 2010 federal health reform law that requires the federal government to create and sponsor a new federal temporary high risk pool, which will begin about July 1, 2010, and end in 2014, in each state that desires one. Defines "federal qualified high risk pool" as the type of high-risk pool provided for under "the federal law" defined above.

Subd. 2. Timing of this section. Makes this section apply beginning as of the date a federal qualified high risk pool begins providing coverage in MN.

Subd. 3. Maintenance of effort. Requires that the dollar-amount of assessments made by the association (MCHA) comply with the federal law's maintenance of (state) effort requirement for state risk pool funding, to the extent that the federal requirement applies to Minnesota's use of a state-required assessment by a semi-private association on its member insurance companies, as compared to a state appropriation.

Subd. Coordination with federal law. Requires that when the federal qualified high-risk pool begins providing coverage in MN, the association stop accepting new enrollees. If that would violate the federal maintenance of effort requirement, requires the association to increase premium subsidies to existing enrollees to the extent necessary to maintain the same overall dollar amount of assessments on health insurance companies.

Subd. 5. Coordination with state health care programs. Requires the commissioner of human services to ensure that (1) applicants for coverage under the federal high-risk pool or the association (MCHA) are referred to medical assistance or MinnesotaCare if they may be qualified for those state programs; and (2) applicants for coverage under those state programs, if determined to be not eligible for them, are provided with information about coverage under the federal high-risk pool and the

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association.

2 **Provider pricing for baskets of care; accountable care organizations.** Amends § 62U.05. The amendment to subdivision 1 requires the commissioner of health, by January 1, 2012, to establish uniform definitions for the total cost of providing all necessary services to a patient through an accountable care organization (ACO) that meets the standards specified in the federal health care reform legislation. Also requires the commissioner to develop a standard method and format for ACOs to use when submitting package prices, and to publish this method in the State Register and make it available to providers.

The amendment to subdivision 2 allows ACOs to establish package prices for the total cost of care beginning July 1, 2012. Beginning July 1, 2012, prohibits ACOs that have established these package prices from varying the amount it accepts as full payment based upon the identity of the payer or patient and other factors.

The amendment to subdivision 3 requires the commissioner to establish quality measures for the total cost of care for services delivered through an ACO by June 30, 2012. Also requires the commissioner or a designee, by January 1, 2013, to publish comparative price and quality information on the total cost of care for services delivered through an ACO.

3 **Accountable care organizations.** Amends § 256B.0754, by adding subd. 3. Requires the commissioner, by July 1, 2012, to deliver services to state health care program enrollees through ACOs, and to provide incentive payments to ACOs that meet or exceed annual quality and performance targets. Requires ACOs to meet the standards specified in federal health care reform legislation.

4 **Coordinated care through a health home.** Adds § 256B.0756.

Subd. 1. Provision of coverage. (a) Requires the commissioner to provide MA coverage of health home services for eligible individuals with chronic conditions who select a designated provider, a team of health care professionals, or a health team as the individual's health home.

(b) Requires the commissioner to implement this section in compliance with the requirements of the Patient Protection and Affordable Care Act (the federal health care reform act). States that terms used in this section have the meaning provided in the federal act.

Subd. 2. Eligible individual. Defines eligible individuals as persons who are eligible for MA and have: (1) two chronic conditions; (2) one chronic condition and are at risk of having a second chronic condition; or (3) one serious and persistent mental health condition.

Subd. 3. Health home services. (a) Defines health home services as comprehensive and timely high-quality services that are provided by a health home. States that these services include: (1) comprehensive care management; (2) care coordination and health promotion; (3) comprehensive transitional care; (4) patient and family support; (5) referral to community and social support services; and (6) use of health information technology to link services.

(b) Requires the commissioner to maximize the number and type of services included

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in this subdivision, to the extent permissible under federal law, including physician, outpatient, mental health treatment, and rehabilitation services necessary for comprehensive transitional care following hospitalization.

Subd. 4. Payments. Directs the commissioner to make payments to health homes for the provision of health home services to eligible individuals.

Subd. 5. Coordination. Requires the commissioner, to the extent feasible, to ensure that the requirements and payment methods for health homes are consistent with state requirements for health care homes. Allows the commissioner to modify requirements and payment methods for health care homes to be consistent with federal health home requirements and payment methods.

Subd. 6. State plan amendment. Requires the commissioner to submit a state plan amendment by January 1, 2011, to implement this section.

Provides that the section is effective January 1, 2011, or upon federal approval, whichever is later.

5 Federal health care reform demonstration projects and grants. (a) Requires the commissioner of human services to seek to participate in the following demonstration projects or apply for the following grants, as described in federal health care reform legislation:

(1) demonstration project to evaluate integrated care around a hospitalization;

(2) Medicaid global payment demonstration project;

(3) pediatric accountable care organization demonstration project;

(4) Medicaid emergency psychiatric demonstration project; and

(5) grants to provide incentives for prevention of chronic diseases in Medicaid.

(b) Requires the commissioner to report to specified legislative chairs and ranking minority members on the status of the demonstration project and grant applications, and if accepted as a participant or awarded a grant, to notify the chairs and ranking minority members of any legislative changes needed to implement the projects or grants.

6 Health Care Reform Task Force.

Subd. 1. Task force. Requires the governor to convene a Health Care Reform Task Force to advise and assist the governor and the legislature in implementing federal health care reform legislation. Specifies membership of the task force and requires the Departments of Health, Human Services, and Commerce to provide staff support. Also allows the task force to accept outside resources.

Subd. 2. Duties. Requires the task force, by December 15, 2010, to develop and present to the legislature and governor a preliminary report and recommendations on state implementation of federal health care reform legislation. Requires the report to contain recommendations on state law and program changes necessary to comply with federal reform legislation, and recommendations for implementing federal reform

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provisions that are optional for states. In developing recommendations, requires the task force to consider the extent to which an approach maximizes federal funding to the state. Also requires the task force, in consultation with the governor and the legislature, to establish timelines and criteria for future reports.

7 American Health Benefit Exchange; planning provisions.

Subd. 1. Federal planning grants. Requires the commissioners of commerce, health, and human services to apply for federal grants made available in the federal health reform legislation. The grants will pay for state planning and creation of state health insurance exchanges required under that legislation.

Subd. 2. Consideration of early creation and operation of exchange. Requires the commissioners referenced in subdivision 1 to analyze the advantages and disadvantages to the state of planning to implement a health insurance exchange before the January 1, 2014, federal deadline for states to do so. Requires the commissioners to provide a written report to the legislature on that subject by December 15, 2010.

Article 8: Human Services Forecast Adjustments

See spreadsheet for details.

Article 9: Health and Human Services Appropriations

See spreadsheet for details.