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ARTICLE 22

HEALTH CARE

Section 1. Minnesota Statutes 2016, section 3.3005, subdivision 8, is amended to read:

Subd. 8. **Request contents.** A request to spend federal funds submitted under this section must include the name of the federal grant, the federal agency from which the funds are available, a federal identification number, a brief description of the purpose of the grant, the amounts expected by fiscal year, an indication if any state match is required, an indication if there is a maintenance of effort requirement, and the number of full-time equivalent positions needed to implement the grant. For new grants, the request must provide a narrative description of the short- and long-term commitments required, including whether continuation of any full-time equivalent positions will be a condition of receiving the federal award.

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ARTICLE 2

HEALTH CARE

Section 1. Minnesota Statutes 2017 Supplement, section 13.69, subdivision 1, is amended to read:

Subdivision 1. **Classifications.** (a) The following government data of the Department of Public Safety are private data:

(1) medical data on driving instructors, licensed drivers, and applicants for parking certificates and special license plates issued to physically disabled persons;

(2) other data on holders of a disability certificate under section 169.345, except that (i) data that are not medical data may be released to law enforcement agencies, and (ii) data necessary for enforcement of sections 169.345 and 169.346 may be released to parking enforcement employees or parking enforcement agents of statutory or home rule charter cities and towns;

(3) Social Security numbers in driver's license and motor vehicle registration records, except that Social Security numbers must be provided to the Department of Revenue for purposes of tax administration, the Department of Labor and Industry for purposes of workers' compensation administration and enforcement, the judicial branch for purposes of debt collection, and the Department of Natural Resources for purposes of license application administration, and except that the last four digits of the Social Security number must be provided to the Department of Human Services for purposes of recovery of Minnesota health care program benefits paid; and

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(4) data on persons listed as standby or temporary custodians under section 171.07, subdivision 11, except that the data must be released to:

(i) law enforcement agencies for the purpose of verifying that an individual is a designated caregiver; or

(ii) law enforcement agencies who state that the license holder is unable to communicate at that time and that the information is necessary for notifying the designated caregiver of the need to care for a child of the license holder.

The department may release the Social Security number only as provided in clause (3) and must not sell or otherwise provide individual Social Security numbers or lists of Social Security numbers for any other purpose.

(b) The following government data of the Department of Public Safety are confidential data: data concerning an individual's driving ability when that data is received from a member of the individual's family.

EFFECTIVE DATE. This section is effective July 1, 2018.

HOUSE ARTICLE 2, SECTION 2 IS MATCHED WITH SENATE ARTICLE 24, SECTION 1

HOUSE ARTICLE 2, SECTIONS 3 AND 4 ARE LOCATED IN THE SENATE ARTICLE 24 SIDE BY SIDE.

Sec. 2. **[62J.90] MINNESOTA HEALTH POLICY COMMISSION.**

Subdivision 1. **Definition.** For purposes of this section, "commission" means the Minnesota Health Policy Commission.

Subd. 2. **Commission membership.** The commission shall consist of 15 voting members, appointed by the Legislative Coordinating Commission as provided in subdivision 9, as follows:

(1) one member with demonstrated expertise in health care finance;

(2) one member with demonstrated expertise in health economics;

(3) one member with demonstrated expertise in actuarial science;

(4) one member with demonstrated expertise in health plan management and finance;

(5) one member with demonstrated expertise in health care system management;

(6) one member with demonstrated expertise as a purchaser, or a representative of a purchaser, of employer-sponsored health care services or employer-sponsored health insurance;

(7) one member with demonstrated expertise in the development and utilization of innovative medical technologies;

(8) one member with demonstrated expertise as a health care consumer advocate;

(9) one member who is a primary care physician;

(10) one member who provides long-term care services through medical assistance;

(11) one member with direct experience as an enrollee, or parent or caregiver of an enrollee, in MinnesotaCare or medical assistance;

(12) two members of the senate, including one member appointed by the majority leader and one member from the minority party appointed by the minority leader; and

(13) two members of the house of representatives, including one member appointed by the speaker of the house and one member from the minority party appointed by the minority leader.

Subd. 3. **Duties.** (a) The commission shall:

(1) compare Minnesota's private market health care costs and public health care program spending to that of the other states;

(2) compare Minnesota's private market health care costs and public health care program spending in any given year to its costs and spending in previous years;

(3) identify factors that influence and contribute to Minnesota's ranking for private market health care costs and public health care program spending, including the year over year and trend line change in total costs and spending in the state;

(4) continually monitor efforts to reform the health care delivery and payment system in Minnesota to understand emerging trends in the health insurance market, including the

private health care market, large self-insured employers, and the state's public health care programs in order to identify opportunities for state action to achieve:

(i) improved patient experience of care, including quality and satisfaction;

(ii) improved health of all populations; and

(iii) reduced per capita cost of health care;

(5) make recommendations for legislative policy, the health care market, or any other reforms to:

(i) lower the rate of growth in private market health care costs and public health care program spending in the state;

(ii) positively impact the state's ranking in the areas listed in this subdivision; and

(iii) improve the quality and value of care for all Minnesotans; and

(6) conduct any additional reviews requested by the legislature.

(b) In making recommendations to the legislature, the commission shall consider:

(i) how the recommendations might positively impact the cost-shifting interplay between public payer reimbursement rates and health insurance premiums; and

(ii) how public health care programs, where appropriate, may be utilized as a means to help prepare enrollees for an eventual transition to the private health care market.

Subd. 4. **Report.** The commission shall submit recommendations for changes in health care policy and financing by June 15 each year to the chairs and ranking minority members of the legislative committees with primary jurisdiction over health care. The report shall include any draft legislation to implement the commission's recommendations.

Subd. 5. **Staff.** The commission shall hire a director who may employ or contract for professional and technical assistance as the commission determines necessary to perform its duties. The commission may also contract with private entities with expertise in health economics, health finance, and actuarial science to secure additional information, data, research, or modeling that may be necessary for the commission to carry out its duties.

Subd. 6. **Access to information.** (a) The commission may request that a state department or agency provide the commission with any publicly available information in a usable format as requested by the commission, at no cost to the commission.

(b) The commission may request from a state department or agency unique or custom data sets and the department or agency may charge the commission for providing the data at the same rate the department or agency would charge any other public or private entity.

(c) Any information provided to the commission by a state department or agency must be de-identified. For purposes of this subdivision, "de-identified" means the process used to prevent the identity of a person or business from being connected with information and ensuring all identifiable information has been removed.

Subd. 7. **Terms; vacancies; compensation.** (a) Public members of the commission shall serve four-year terms. The public members may not serve for more than two consecutive terms.

(b) The legislative members shall serve on the commission as long as the member or the appointing authority holds office.

(c) The removal of members and filling of vacancies on the commission are as provided in section 15.059.

(d) Public members may receive compensation and expenses as provided in section 15.059, subdivision 3.

Subd. 8. **Chairs; officers.** The commission shall elect a chair annually. The commission may elect other officers necessary for the performance of its duties.

Subd. 9. **Selection of members; advisory council.** The Legislative Coordinating Commission shall take applications from members of the public who are qualified and interested to serve in one of the listed positions. The applications must be reviewed by a health policy commission advisory council comprised of four members as follows: the state economist, legislative auditor, state demographer, and the president of the Federal Reserve Bank of Minneapolis or a designee of the president. The advisory council shall recommend two applicants for each of the specified positions by September 30 in the calendar year preceding the end of the members' terms. The Legislative Coordinating Commission shall appoint one of the two recommended applicants to the commission.

Subd. 10. **Meetings.** The commission shall meet at least four times each year. Commission meetings are subject to chapter 13D.

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Subd. 11. **Conflict of interest.** A member of the commission may not participate in or vote on a decision of the commission relating to an organization in which the member has either a direct or indirect financial interest.

Subd. 12. **Expiration.** The commission shall expire on June 15, 2024.

Sec. 3. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to read:

Subd. 17a. **Transfers for routine administrative operations.** (a) Unless specifically authorized by law, the commissioner may only transfer money from the general fund to any other fund for routine administrative operations and may not transfer money from the general fund to any other fund without approval from the commissioner of management and budget. If the commissioner of management and budget determines that a transfer proposed by the commissioner is necessary for routine administrative operations of the Department of Human Services, the commissioner may approve the transfer. If the commissioner of management and budget determines that the transfer proposed by the commissioner is not necessary for routine administrative operations of the Department of Human Services, the commissioner may not approve the transfer unless the requirements of paragraph (b) are met.

(b) If the commissioner of management and budget determines that a transfer under paragraph (a) is not necessary for routine administrative operations of the Department of Human Services, the commissioner may request approval of the transfer from the Legislative Advisory Commission under section 3.30. To request approval of a transfer from the Legislative Advisory Commission, the commissioner must submit a request that includes the amount of the transfer, the budget activity and fund from which money would be transferred and the budget activity and fund to which money would be transferred, an explanation of the administrative necessity of the transfer, and a statement from the commissioner of management and budget explaining why the transfer is not necessary for routine administrative operations of the Department of Human Services. The Legislative Advisory Commission shall review the proposed transfer and make a recommendation within 20 days of the request from the commissioner. If the Legislative Advisory Commission makes a positive recommendation or no recommendation, the commissioner may approve the transfer. If the Legislative Advisory Commission makes a negative recommendation or a request for more information, the commissioner may not approve the transfer. A recommendation of the Legislative Advisory Commission must be made by a majority of the commission and must be made at a meeting of the commission unless a written recommendation is signed by a majority of the commission members required to vote on

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HOUSE ARTICLE 11

Sec. 6. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to read:

Subd. 17a. **Transfers for routine administrative operations.** (a) The commissioner may only transfer money from the general fund to any other fund for routine administrative operations and may not transfer money from the general fund to any other fund without approval from the commissioner of management and budget unless specifically authorized by law. If the commissioner of management and budget determines that a transfer proposed by the commissioner is necessary for routine administrative operations of the Department of Human Services, the commissioner may approve the transfer. If the commissioner of management and budget determines that the transfer proposed by the commissioner is not necessary for routine administrative operations of the Department of Human Services, the commissioner may not approve the transfer unless the requirements of paragraph (b) are met.

(b) If the commissioner of management and budget determines that a transfer under paragraph (a) is not necessary for routine administrative operations of the Department of Human Services, the commissioner may request approval of the transfer from the Legislative Advisory Commission under section 3.30. To request approval of a transfer from the Legislative Advisory Commission, the commissioner must submit a request that includes the amount of the transfer, the budget activity and fund from which money would be transferred and the budget activity and fund to which money would be transferred, an explanation of the administrative necessity of the transfer, and a statement from the commissioner of management and budget explaining why the transfer is not necessary for routine administrative operations of the Department of Human Services. The Legislative Advisory Commission shall review the proposed transfer and make a recommendation within 20 days of the request from the commissioner. If the Legislative Advisory Commission makes a positive recommendation or no recommendation, the commissioner may approve the transfer. If the Legislative Advisory Commission makes a negative recommendation or a request for more information, the commissioner may not approve the transfer. A recommendation of the Legislative Advisory Commission must be made by a majority of the commission and must be made at a meeting of the commission unless a written recommendation is signed by a majority of the commission members required to vote on

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the question. If the commission makes a negative recommendation or a request for more information, the commission may withdraw or change its recommendation.

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the question. If the commission makes a negative recommendation or a request for more information, the commission may subsequently withdraw or change its recommendation.

HOUSE ARTICLE 2

Sec. 5. **[256.0113] ELIGIBILITY VERIFICATION.**

Subdivision 1. **Verification required; vendor contract.** (a) The commissioner shall ensure that medical assistance, MinnesotaCare, and Supplemental Nutrition Assistance Program (SNAP) eligibility determinations through the MNsure information technology system and through other agency eligibility determination systems include the computerized verification of income, residency, identity, and when applicable, assets and compliance with SNAP work requirements.

(b) The commissioner shall contract with a vendor to verify the eligibility of all persons enrolled in medical assistance, MinnesotaCare, and SNAP during a specified audit period. This contract shall be exempt from sections 16C.08, subdivision 2, clause (1); 16C.09, paragraph (a), clause (1); 43A.047, paragraph (a), and any other law to the contrary.

(c) The contract must require the vendor to comply with enrollee data privacy requirements and to use encryption to safeguard enrollee identity. The contract must also provide penalties for vendor noncompliance.

(d) The contract must include a revenue sharing agreement, under which vendor compensation is limited to a portion of any savings to the state resulting from the vendor's implementation of eligibility verification initiatives under this section.

(e) The commissioner shall use existing resources to fund any agency administrative and technology-related costs incurred as a result of implementing this section.

(f) All state savings resulting from implementation of the vendor contract under this section, minus any payments to the vendor made under the terms of the revenue sharing agreement, shall be deposited into the health care access fund.

Subd. 2. **Verification process; vendor duties.** (a) The verification process implemented by the vendor must include but is not limited to data matches of the name, date of birth, address, and Social Security number of each medical assistance, MinnesotaCare, and SNAP enrollee against relevant information in federal and state data sources, including the federal data hub established under the Affordable Care Act. In designing the verification process, the vendor, to the extent feasible, shall incorporate procedures that are compatible and

coordinated with, and build upon or improve, existing procedures used by the MNsure information technology system and other agency eligibility determination systems.

(b) The vendor, upon preliminary determination that an enrollee is eligible or ineligible, shall notify the commissioner. Within 20 business days of notification, the commissioner shall accept the preliminary determination or reject the preliminary determination with a stated reason. The commissioner shall retain final authority over eligibility determinations. The vendor shall keep a record of all preliminary determinations of ineligibility submitted to the commissioner.

(c) The vendor shall recommend to the commissioner an eligibility verification process that allows ongoing verification of enrollee eligibility under the MNsure information technology system and other agency eligibility determination systems.

(d) The commissioner and the vendor, following the conclusion of the initial contract period, shall jointly submit an eligibility verification audit report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. The report shall include but is not limited to information in the form of unidentified summary data on preliminary determinations of eligibility or ineligibility communicated by the vendor, the actions taken on those preliminary determinations by the commissioner, and the commissioner's reasons for rejecting preliminary determinations by the vendor. The report must also include the recommendations for ongoing verification of enrollee eligibility required under paragraph (c).

(e) An eligibility verification vendor contract shall be awarded for an initial one-year period, beginning January 1, 2019. The commissioner shall renew the contract for up to three additional one-year periods and require additional eligibility verification audits, if the commissioner or the legislative auditor determines that the MNsure information technology system and other agency eligibility determination systems cannot effectively verify the eligibility of medical assistance, MinnesotaCare, and SNAP enrollees.

Sec. 6. Minnesota Statutes 2016, section 256.014, subdivision 2, is amended to read:

Subd. 2. **State systems account created.** (a) A state systems account is created in the state treasury. Money collected by the commissioner of human services for the programs in subdivision 1 must be deposited in the account. Money in the state systems account and federal matching money is appropriated to the commissioner of human services for purposes of this section. Any unexpended balance in the appropriations for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, or SSIS does not cancel and is available for ongoing development and operations, subject to review by the Legislative Advisory Commission under paragraphs (b) and (c).

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(b) No unexpended balance under paragraph (a) may be expended by the commissioner of human services until the commissioner of management and budget has submitted the proposed expenditure to the members of the Legislative Advisory Commission for review and recommendation. If the commission makes a positive recommendation or no recommendation, or if the commission has not reviewed the request within 20 days after the date the proposed expenditure was submitted, the commissioner of management and budget may approve the proposed expenditure. If the commission recommends further review of the proposed expenditure, the commissioner shall provide additional information to the commission. If the commission makes a negative recommendation on the proposed expenditure within ten days of receiving further information, the commissioner shall not approve the proposed expenditure. If the commission makes a positive recommendation or no recommendation within ten days of receiving further information, the commissioner may approve the proposed expenditure.

(c) A recommendation of the commission must be made at a meeting of the commission unless a written recommendation is signed by all members entitled to vote on the item as specified in section 3.30, subdivision 2. A recommendation of the commission must be made by a majority of the commission.

Sec. 4. Minnesota Statutes 2016, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies; and

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

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(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems;

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; and

(6) drugs.

(b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation ~~for special transportation services~~ under the provisions of chapter 16C for special transportation services or incontinence products and related supplies.

Sec. 5. Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week, except as provided in paragraph (f). Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

Sec. 7. Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week, except as provided in paragraph (f). Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

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(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or

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(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or

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support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6~~, and~~, a community paramedic as defined under section 144E.001, subdivision 5f; or a mental health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

(f) The limit on coverage of three telemedicine services per enrollee per calendar week does not apply if:

(1) the telemedicine services provided by the licensed health care provider are for the treatment and control of tuberculosis; and

(2) the services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention.

Sec. 6. Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

(b) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, nonemergency medical transportation company, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs that meet the requirements of this subdivision;

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support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6, a community paramedic as defined under section 144E.001, subdivision 5f, and a mental health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

(f) The limit on coverage of three telemedicine services per enrollee per calendar week does not apply if:

(1) the telemedicine services provided by the licensed health care provider are for the treatment and control of tuberculosis; and

(2) the services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the commissioner of health.

(4) public transit, as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers.

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840~~, and in consultation with the Minnesota Department of Transportation~~. All drivers providing nonemergency medical transportation must be individually enrolled with the commissioner if the driver is a subcontractor for or employed by a provider that both has a base of operation located within a metropolitan county listed in section 437.121, subdivision 4, and is listed in paragraph (b), clause (1) or (3). All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

(d) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

(e) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a Web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services.

(f) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

(g) The commissioner may use an order by the recipient's attending physician or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency.

Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(h) The administrative agency shall use the level of service process established by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(i) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(j) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the commissioner has developed, made available, and funded the Web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government.

(k) The commissioner shall:

(1) in consultation with the Nonemergency Medical Transportation Advisory Committee, verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(l) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care,

local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(m) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (h), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $11 for the base rate and $1.30 per mile when provided by a nonemergency medical transportation provider;

(4) $13 for the base rate and $1.30 per mile for assisted transport;

(5) $18 for the base rate and $1.55 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary.

(n) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (m), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (m), clauses (1) to (7).

(o) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (m) and (n), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

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(p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(q) The commissioner, when determining reimbursement rates for nonemergency medical transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

EFFECTIVE DATE. Paragraph (c) is effective January 1, 2019.

Sec. 7. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17d. **Transportation services oversight.** The commissioner shall contract with a vendor or dedicate staff for oversight of providers of nonemergency medical transportation services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules, parts 9505.2160 to 9505.2245.

EFFECTIVE DATE. This section is July 1, 2018.

Sec. 8. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17e. **Transportation provider termination.** (a) A terminated nonemergency medical transportation provider, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the nonemergency medical transportation provider, is not eligible to enroll as a nonemergency medical transportation provider for five years following the termination.

(b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a nonemergency medical transportation provider, the nonemergency medical transportation provider must be placed on a one-year probation period. During a provider's probation period, the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 9. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17f. **Transportation provider training.** The commissioner shall make available to providers of nonemergency medical transportation and all drivers training materials and

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Sec. 8. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17d. **Transportation services oversight.** The commissioner shall contract with a vendor or dedicate staff for oversight of providers of nonemergency medical transportation services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules, parts 9505.2160 to 9505.2245.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 9. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17e. **Transportation provider termination.** (a) A terminated nonemergency medical transportation provider, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the nonemergency medical transportation provider, is not eligible to enroll as a nonemergency medical transportation provider for five years following the termination.

(b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a nonemergency medical transportation provider, the nonemergency medical transportation provider must be placed on a one-year probation period. During a provider's probation period the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements.

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

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online training opportunities regarding documentation requirements, documentation procedures, and penalties for failing to meet documentation requirements.

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Sec. 10. Minnesota Statutes 2016, section 256B.0625, subdivision 18d, is amended to read:

Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical Transportation Advisory Committee consists of:

(1) four voting members who represent counties, utilizing the rural urban commuting area classification system. As defined in subdivision 17, these members shall be designated as follows:

(i) two counties within the 11-county metropolitan area;

(ii) one county representing the rural area of the state; and

(iii) one county representing the super rural area of the state.

The Association of Minnesota Counties shall appoint one county within the 11-county metropolitan area and one county representing the super rural area of the state. The Minnesota Inter-County Association shall appoint one county within the 11-county metropolitan area and one county representing the rural area of the state;

(2) three voting members who represent medical assistance recipients, including persons with physical and developmental disabilities, persons with mental illness, seniors, children, and low-income individuals;

(3) ~~four~~ five voting members who represent providers that deliver nonemergency medical transportation services to medical assistance enrollees, one of whom is a taxicab owner or operator;

(4) two voting members of the house of representatives, one from the majority party and one from the minority party, appointed by the speaker of the house, and two voting members from the senate, one from the majority party and one from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(5) one voting member who represents demonstration providers as defined in section 256B.69, subdivision 2;

(6) one voting member who represents an organization that contracts with state or local governments to coordinate transportation services for medical assistance enrollees;

(7) one voting member who represents the Minnesota State Council on Disability;

(8) the commissioner of transportation or the commissioner's designee, who shall serve as a voting member;

(9) one voting member appointed by the Minnesota Ambulance Association; and

(10) one voting member appointed by the Minnesota Hospital Association.

(b) Members of the advisory committee shall not be employed by the Department of Human Services. Members of the advisory committee shall receive no compensation.

Sec. 11. Minnesota Statutes 2016, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

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

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for

essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

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

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

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

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

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

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

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

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

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

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

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~~(h) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by federally qualified health centers and rural health clinics shall be paid by the commissioner. the commissioner shall determine the most feasible method for paying claims from the following options:~~

~~(1) federally qualified health centers and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or~~

~~(2) federally qualified health centers and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.~~

(h) Federally qualified health centers and rural health clinics shall submit claims directly to the commissioner for payment, and the commissioner shall provide claims information for recipients enrolled in a managed care plan or county-based purchasing plan to the plan on a regular basis as determined by the commissioner.

(i) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

(j) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization in accordance with section 1905(b) of the Social Security Act for expenditures made to organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2019, and applies to services provided on or after that date.

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Sec. 10. Minnesota Statutes 2016, section 256B.0625, subdivision 58, is amended to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** (a) Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). The payment amount for a complete EPSDT screening shall not include charges for health care services and products that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

(b) A provider is not required to perform as part of an EPSDT screening any of the recommendations that were added on or after January 1, 2017, to the child and teen checkup program periodicity schedule, in order to receive the full payment amount for a complete EPSDT screening. This paragraph expires January 1, 2021.

(c) The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services of any new recommendations added to an EPSDT screening after January 1, 2018, that the provider is required to perform as part of an EPSDT screening to receive the full payment amount.

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Sec. 12. **[256B.0759] DIRECT CONTRACTING PILOT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner shall establish a direct contracting pilot program to test alternative and innovative methods of delivering care through community-based collaborative care networks to medical assistance and MinnesotaCare enrollees. The pilot program shall be designed to coordinate care delivery to enrollees who demonstrate a combination of medical, economic, behavioral health, cultural, and geographic risk factors, including persons determined to be at risk of substance abuse and opioid addiction. The commissioner shall issue a request for proposals to select care networks to deliver care through the pilot program for a three-year period beginning January 1, 2020.

Subd. 2. **Eligible individuals.** (a) The pilot program shall serve individuals who:

(1) are eligible for medical assistance under section 256B.055 or MinnesotaCare under chapter 256L;

(2) reside in the service area of the care network;

(3) have a combination of multiple risk factors identified by the care network and approved by the commissioner;

(4) have elected to participate in the pilot project as an alternative to receiving services under fee-for-service or through a managed care or county-based purchasing plan or integrated health partnership; and

(5) agree to participate in risk mitigation strategies as provided in subdivision 4, clause (4), if the individual is determined to be at risk of opioid addiction or substance abuse.

(b) The commissioner may identify individuals who are potentially eligible to be enrolled with a care network based on zip code or other geographic designation, utilization history, or other factors indicating whether an individual resides in the service area of a care network. The commissioner shall coordinate pilot program enrollment with the enrollment and procurement process for managed care and county-based purchasing plans and integrated health partnerships.

Subd. 3. **Selection of care networks.** Participation in the pilot program is limited to no more than six care networks. The commissioner shall ensure that the care networks selected serve different geographic areas of the state. The commissioner shall consider the following criteria when selecting care networks to participate in the program:

(1) the ability of the care network to provide or arrange for the full range of health care services required to be provided under section 256B.69, including but not limited to primary care, inpatient hospital care, specialty care, behavioral health services, and chemical dependency and substance abuse treatment services;

(2) at least 25,000 individuals reside in the service area of the care network;

(3) the care network serves a high percentage of patients who are enrolled in Minnesota health care programs or are uninsured compared to the overall Minnesota population; and

(4) the care network can demonstrate the capacity to improve health outcomes and reduce total cost of care for the population in its service area through better patient engagement, coordination of care, and the provision of specialized services to address risk factors related to opioid addiction and substance abuse, and address nonclinical risk factors and barriers to access.

Subd. 4. **Requirements for participating care networks.** (a) A care network selected to participate in the pilot program must:

(1) accept a capitation rate for enrollees equal to the capitation rate that would otherwise apply to the enrollees under section 256B.69;

(2) comply with all requirements in section 256B.69 related to performance targets, capitation rate withholds, and administrative expenses;

(3) maintain adequate reserves and demonstrate the ability to bear risk, based upon criteria established by the commissioner under the request for proposals, or demonstrate to the commissioner that this requirement has been met through a contract with a health plan company, third-party administrator, stop-loss insurer, or other entity; and

(4) assess all enrollees for risk factors related to opioid addiction and substance abuse and, based upon the professional judgment of the health care provider, require enrollees determined to be at risk to enter into a patient provider agreement, submit to urine drug screening, and participate in other risk mitigation strategies; and

(5) participate in quality of care and financial reporting initiatives, in the form and manner specified by the commissioner.

(b) An existing integrated health partnership that meets the criteria in this section is eligible to participate in the pilot program while continuing as an integrated health partnership.

Subd. 5. **Requirements for the commissioner.** (a) The commissioner shall provide all participating care networks with enrollee utilization and cost information similar to that provided by the commissioner to integrated health partnerships.

(b) The commissioner, in consultation with the commissioner of health and care networks, shall design and administer the pilot program in a manner that allows the testing of new care coordination models and quality-of-care measures to determine the extent to which the care delivered by the pilot program, relative to the care delivered under fee-for-service and by managed care and county-based purchasing plans and integrated health partnerships:

(1) improves outcomes and reduces the total cost of care for the population served; and

(2) reduces administrative burdens and costs for health care providers and state agencies.

(c) The commissioner, based on the analysis under paragraph (b), shall evaluate the pilot program and present recommendations as to whether the pilot program should be continued or expanded to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 15, 2022.

Sec. 13. Minnesota Statutes 2016, section 256B.69, subdivision 5a, is amended to read:

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Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

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

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program 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 or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

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

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) 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 reduction 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 emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in 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.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) 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 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 hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). 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.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations 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 hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in 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 qualifying 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, excluding enrollees in programs described in subdivisions 23 and 28, 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.

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

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

(j) 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.

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

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

(n) Effective for services provided on or after January 1, 2019, through December 31, 2019, the commissioner shall withhold two percent of the capitation payment provided to managed care plans under this section, and county-based purchasing plans under section 256B.692, for each medical assistance enrollee. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year, for capitation payments for enrollees for whom the plan has submitted to the commissioner a verification of coverage form completed and signed by the enrollee. The verification of coverage form must be developed by the commissioner and made available to managed care and county-based purchasing plans. The form must require the enrollee to provide the enrollee's name and street address and the name of the managed care or county-based purchasing plan selected by or assigned to the enrollee and must include a signature block that allows the enrollee to attest that the information provided is accurate. A plan shall request that all enrollees complete the verification of coverage form and shall submit all completed forms to the

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commissioner by February 28, 2019. If a completed form for an enrollee is not received by the commissioner by that date:

(1) the commissioner shall not return to the plan funds withheld for that enrollee;

(2) the commissioner shall cease making capitation payments to the plan for that enrollee, effective with the April 2019 coverage month; and

(3) the commissioner shall disenroll the enrollee from medical assistance, subject to any enrollee appeal.

(o) The commissioner may establish and administer a single preferred drug list for medical assistance and MinnesotaCare enrollees receiving services through fee-for-service, integrated health partnerships, managed care, or county-based purchasing, only if the commissioner first studies this change and then obtains legislative approval in the form of enacted legislation authorizing the change. In conducting the study, the commissioner shall consult with interested and affected stakeholders including but not limited to managed care organizations, county-based purchasers, integrated health partnerships, health care providers, and enrollees. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on the anticipated impact of the proposed change on: the state budget, access to services, quality of both outcomes and enrollee experience, and administrative efficiency. The report must also include an assessment of possible unintended consequences of the use of a single preferred drug list.

Sec. 11. **]256B.758[REIMBURSEMENT FOR DOULA SERVICES.**

Effective for services provided on or after July 1, 2018, payments for doula services provided by a certified doula shall be $47 per prenatal or postpartum visit, up to a total of six visits; and $488 for attending and providing doula services at a birth.

Sec. 12. Laws 2017, First Special Session chapter 6, article 4, section 61, is amended to read:

Sec. 61. **CAPITATION PAYMENT DELAY.**

(a) The commissioner of human services shall delay the medical assistance capitation payment to managed care plans and county-based purchasing plans due in May 2019 until July 1, 2019. The payment shall be made no earlier than July 1, 2019, and no later than July 31, 2019.

(b) The commissioner of human services shall delay the medical assistance capitation payment to managed care plans and county-based purchasing plans due in May 2021 until

July 1, 2021. The payment shall be made no earlier than July 1, 2021, and no later than July 31, 2021. This paragraph does not apply to the capitation payment for adults without dependent children.

Sec. 13. **DIRECTION TO COMMISSIONER.**

By August 1, 2020, the commissioner of human services shall issue a report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services. The commissioner must include in the report the commissioner's findings regarding the impact of driver enrollment under Minnesota Statutes, section 256B.0625, subdivision 17, paragraph (c), on the program integrity of the nonemergency medical transportation program. The commissioner must include a recommendation, based on the findings in the report, regarding expanding the driver enrollment requirement.

Sec. 14. **MINNESOTA HEALTH POLICY COMMISSION; FIRST APPOINTMENTS; FIRST MEETING.**

The Health Policy Commission Advisory Council shall make its recommendations under Minnesota Statutes, section 62J.90, subdivision 9, for candidates to serve on the Minnesota Health Policy Commission to the Legislative Coordinating Commission by September 30, 2018. The Legislative Coordinating Commission shall make the first appointments of public members to the Minnesota Health Policy Commission under Minnesota Statutes, section 62J.90, by January 15, 2019. The Legislative Coordinating Commission shall designate five members to serve terms that are coterminous with the governor and six members to serve terms that end on the first Monday in January one year after the terms of the other members conclude. The director of the Legislative Coordinating Commission shall convene the first meeting of the Minnesota Health Policy Commission by June 15, 2019, and shall act as the chair until the commission elects a chair at its first meeting.

Sec. 15. **PAIN MANAGEMENT.**

(a) The Health Services Policy Committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall evaluate and make recommendations on the integration of nonpharmacologic pain management that are clinically viable and sustainable; reduce or eliminate chronic pain conditions; improve functional status; and prevent addiction and reduce dependence on opiates or other pain medications. The recommendations must be based on best practices for the effective treatment of musculoskeletal pain provided by health practitioners identified in paragraph (b), and covered under medical assistance. Each health practitioner represented under paragraph (b) shall present the minimum best integrated practice recommendations, policies, and scientific evidence for nonpharmacologic treatment options for eliminating pain and improving functional status within their full professional

Senate Language S3656-2

scope. Recommendations for integration of services may include guidance regarding screening for co-occurring behavioral health diagnoses; protocols for communication between all providers treating a unique individual, including protocols for follow-up; and universal mechanisms to assess improvements in functional status.

(b) In evaluating and making recommendations, the Health Services Policy Committee shall consult and collaborate with the following health practitioners: acupuncture practitioners licensed under Minnesota Statutes, chapter 147B; chiropractors licensed under Minnesota Statutes, sections 148.01 to 148.10; physical therapists licensed under Minnesota Statutes, sections 148.68 to 148.78; medical and osteopathic physicians licensed under Minnesota Statutes, chapter 147, and advanced practice registered nurses licensed under Minnesota Statutes, sections 148.171 to 148.285, with experience in providing primary care collaboratively within a multidisciplinary team of health care practitioners who employ nonpharmacologic pain therapies; and psychologists licensed under Minnesota Statutes, section 148.907.

(c) The commissioner shall submit a progress report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2019, and shall report final recommendations by August 1, 2019. The final report may also contain recommendations for developing and implementing a pilot program to assess the clinical viability, sustainability, and effectiveness of integrated nonpharmacologic, multidisciplinary treatments for managing musculoskeletal pain and improving functional status.

House Language H3138-3

Sec. 14. **ENCOUNTER REPORTING OF 340B ELIGIBLE DRUGS.**

(a) The commissioner of human services, in consultation with federally qualified health centers, managed care organizations, and contract pharmacies, shall develop recommendations for a process to identify and report at point of sale the 340B drugs that are dispensed to enrollees of managed care organizations who are patients of a federally qualified health center, and to exclude these claims from the Medicaid Drug Rebate Program and ensure that duplicate discounts for drugs do not occur. In developing this process, the commissioner shall assess the impact of allowing federally qualified health centers to utilize the 340B Drug Pricing Program drug discounts if a federally qualified health center utilizes a contract pharmacy for a patient enrolled in the prepaid medical assistance program.

(b) By March 1, 2019, the commissioner shall report the recommendations to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over medical assistance.

Sec. 15. **RECONCILIATION OF MINNESOTACARE PREMIUMS.**

Subdivision 1. **Reconciliation required.** (a) The commissioner of human services shall reconcile all MinnesotaCare premiums paid or due for health coverage provided during the period January 1, 2014, through December 31, 2017, by July 1, 2018. Based on this reconciliation, the commissioner shall notify each MinnesotaCare enrollee or former enrollee of any amount owed as premiums, refund to the enrollee or former enrollee any premium overpayment, and enter into a payment arrangement with the enrollee or former enrollee as necessary.

(b) The commissioner of human services is prohibited from using agency staff and resources to plan, develop, or promote any proposal that would offer a health insurance product on the individual market that would offer consumers similar benefits and networks as the standard MinnesotaCare program, until the commissioner of management and budget has determined under subdivision 2 that the commissioner is in compliance with the requirements of this section.

Subd. 2. **Determination of compliance; contingent transfer.** The commissioner of management and budget shall determine whether the commissioner of human services has complied with the requirements of subdivision 1. If the commissioner of management and budget determines that the commissioner of human services is not in compliance with subdivision 1, the commissioner of management and budget shall transfer $10,000 from the central office operations account of the Department of Human Services to the premium security plan account established under Minnesota Statutes, section 62E.25, for each business day of noncompliance.

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

Sec. 16. **CONTRACT TO RECOVER THIRD-PARTY LIABILITY.**

The commissioner shall contract with a vendor to implement a third-party liability recovery program for medical assistance and MinnesotaCare. Under the terms of the contract, the vendor shall be reimbursed using a percentage of the money recovered through the third-party liability recovery program. All money recovered that remains after reimbursement of the vendor is available for operation of the medical assistance and MinnesotaCare programs. The use of this money must be authorized in law by the legislature.

EFFECTIVE DATE. This section is effective July 1, 2018.

HOUSE ARTICLE 2, SECTIONS 17, 18, 19, AND 20 ARE LOCATED IN THE SENATE ARTICLE 24 SIDE BY SIDE.

Sec. 16. **REPEALER.**

(a) Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 31c, is repealed.

(b) Minnesota Statutes 2016, section 256B.0625, subdivision 18b, is repealed.