331.1 **ARTICLE 10**
331.2 **HEALTH CARE**

331.3 Section 1. Minnesota Statutes 2014, section 16A.724, subdivision 2, is amended to read:

331.4 Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available
331.5 resources in the health care access fund exceed expenditures in that fund, effective for
331.6 the biennium beginning July 1, 2007, the commissioner of management and budget shall
331.7 transfer the excess funds from the health care access fund to the general fund on June 30
331.8 of each year, provided that the amount transferred in any fiscal biennium shall not exceed
331.9 $96,000,000. The purpose of this transfer is to meet the rate increase required under Laws
331.10 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

331.11 (b) ~~For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and,~~
331.12 ~~if necessary,~~ The commissioner shall reduce these transfers from the health care access
331.13 fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary,
331.14 transfer sufficient funds from the general fund to the health care access fund to meet
331.15 annual MinnesotaCare expenditures.

331.16 (c) Notwithstanding section 295.581, to the extent available resources in the health
331.17 care access fund exceed expenditures in that fund after the transfer required in paragraph
331.18 (a), effective for the biennium beginning July 1, 2013, the commissioner of management
331.19 and budget shall transfer $1,000,000 each fiscal year from the health access fund to
331.20 the medical education and research costs fund established under section 62J.692, for
331.21 distribution under section 62J.692, subdivision 4, paragraph (c).

331.22 Sec. 2. Minnesota Statutes 2014, section 62A.045, is amended to read:
331.23 **62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT**
331.24 **HEALTH PROGRAMS.**

331.25 (a) As a condition of doing business in Minnesota or providing coverage to
331.26 residents of Minnesota covered by this section, each health insurer shall comply with the
331.27 requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171, including
331.28 any federal regulations adopted under that act, to the extent that it imposes a requirement
331.29 that applies in this state and that is not also required by the laws of this state. This section
331.30 does not require compliance with any provision of the federal act prior to the effective date
331.31 provided for that provision in the federal act. The commissioner shall enforce this section.

3.5 **ARTICLE 1**
3.6 **HEALTH CARE**
54.25 **ARTICLE 2**
54.26 **MINNESOTACARE**

THERE ARE MULTIPLE SECTIONS WITH THE SAME SECTION NUMBER ON THE HOUSE SIDE BECAUSE TWO HOUSE ARTICLES ARE COMPARED TO ONE SENATE ARTICLE.

3.7 Section 1. Minnesota Statutes 2014, section 62A.045, is amended to read:
3.8 **62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT**
3.9 **HEALTH PROGRAMS.**

3.10 (a) As a condition of doing business in Minnesota or providing coverage to
3.11 residents of Minnesota covered by this section, each health insurer shall comply with the
3.12 requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171, including
3.13 any federal regulations adopted under that act, to the extent that it imposes a requirement
3.14 that applies in this state and that is not also required by the laws of this state. This section
3.15 does not require compliance with any provision of the federal act prior to the effective date
3.16 provided for that provision in the federal act. The commissioner shall enforce this section.

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

332.3 (b) No plan offered by a health insurer issued or renewed to provide coverage to
332.4 a Minnesota resident shall contain any provision denying or reducing benefits because
332.5 services are rendered to a person who is eligible for or receiving medical benefits pursuant
332.6 to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256;
332.7 256B; or 256D or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331,
332.8 subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer
332.9 providing benefits under plans covered by this section shall use eligibility for medical
332.10 programs named in this section as an underwriting guideline or reason for nonacceptance
332.11 of the risk.

332.12 (c) If payment for covered expenses has been made under state medical programs for
332.13 health care items or services provided to an individual, and a third party has a legal liability
332.14 to make payments, the rights of payment and appeal of an adverse coverage decision for the
332.15 individual, or in the case of a child their responsible relative or caretaker, will be subrogated
332.16 to the state agency. The state agency may assert its rights under this section within three
332.17 years of the date the service was rendered. For purposes of this section, "state agency"
332.18 includes prepaid health plans under contract with the commissioner according to sections
332.19 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health
332.20 collaboratives under section 245.493; demonstration projects for persons with disabilities
332.21 under section 256B.77; nursing homes under the alternative payment demonstration project
332.22 under section 256B.434; and county-based purchasing entities under section 256B.692.

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

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

3.22 (b) No plan offered by a health insurer issued or renewed to provide coverage to
3.23 a Minnesota resident shall contain any provision denying or reducing benefits because
3.24 services are rendered to a person who is eligible for or receiving medical benefits pursuant
3.25 to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256;
3.26 256B; or 256D or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331,
3.27 subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer
3.28 providing benefits under plans covered by this section shall use eligibility for medical
3.29 programs named in this section as an underwriting guideline or reason for nonacceptance
3.30 of the risk.

3.31 (c) If payment for covered expenses has been made under state medical programs for
3.32 health care items or services provided to an individual, and a third party has a legal liability
3.33 to make payments, the rights of payment and appeal of an adverse coverage decision for the
3.34 individual, or in the case of a child their responsible relative or caretaker, will be subrogated
3.35 to the state agency. The state agency may assert its rights under this section within three
4.1 years of the date the service was rendered. For purposes of this section, "state agency"
4.2 includes prepaid health plans under contract with the commissioner according to sections
4.3 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health
4.4 collaboratives under section 245.493; demonstration projects for persons with disabilities
4.5 under section 256B.77; nursing homes under the alternative payment demonstration project
4.6 under section 256B.434; and county-based purchasing entities under section 256B.692.

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

Senate Language S1458-2

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

333.7 (f) A health insurer must process a clean claim made by a state agency for covered
333.8 expenses paid under state medical programs within 90 business days of the claim's
333.9 submission. A health insurer must process all other claims made by a state agency for
333.10 covered expenses paid under a state medical program within the timeline set forth in Code
333.11 of Federal Regulations, title 42, section 447.45(d)(4).

333.12 (g) A health insurer may request a refund of a claim paid in error to the Department
333.13 of Human Services within two years of the date the payment was made to the department.
333.14 A request for a refund shall not be honored by the department if the health insurer makes
333.15 the request after the time period has lapsed.

333.16 Sec. 3. Minnesota Statutes 2014, section 174.29, subdivision 1, is amended to read:

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

4.26 (f) A health insurer must process a claim made by a state agency for covered
4.27 expenses paid under state medical programs within 90 business days of the claim's
4.28 submission. If the health insurer needs additional information to process the claim,
4.29 the health insurer may be granted an additional 30 business days to process the claim,
4.30 provided the health insurer submits the request for additional information to the state
4.31 agency within 30 business days after the health insurer received the claim.

4.32 (g) A health insurer may request a refund of a claim paid in error to the Department
4.33 of Human Services within two years of the date the payment was made to the department.
4.34 A request for a refund shall not be honored by the department if the health insurer makes
4.35 the request after the time period has lapsed.

5.1 Sec. 2. Minnesota Statutes 2014, section 150A.06, subdivision 1b, is amended to read:

5.2 Subd. 1b. **Resident dentists.** A person who is a graduate of a dental school and
5.3 is an enrolled graduate student or student of an accredited advanced dental education
5.4 program and who is not licensed to practice dentistry in the state shall obtain from the
5.5 board a license to practice dentistry as a resident dentist. The license must be designated
5.6 "resident dentist license" and authorizes the licensee to practice dentistry only under the
5.7 supervision of a licensed dentist. A University of Minnesota School of Dentistry dental
5.8 resident holding a resident dentist license is eligible for enrollment in medical assistance,
5.9 as provided under section 256B.0625, subdivision 9b. A resident dentist license must be
5.10 renewed annually pursuant to the board's rules. An applicant for a resident dentist license
5.11 shall pay a nonrefundable fee set by the board for issuing and renewing the license. The
5.12 requirements of sections 150A.01 to 150A.21 apply to resident dentists except as specified
5.13 in rules adopted by the board. A resident dentist license does not qualify a person for
5.14 licensure under subdivision 1.

ARTICLE 1, SECTIONS 3 AND 4 MOVED TO HEALTH CARE DELIVERY, SENATE ARTICLE 8/HOUSE ARTICLE 6.

333.17 Subdivision 1. **Definition.** For the purpose of sections 174.29 and 174.30 "special
333.18 transportation service" means motor vehicle transportation provided on a regular basis
333.19 by a public or private entity or person that is designed exclusively or primarily to serve
333.20 individuals who are elderly or disabled and who are unable to use regular means of
333.21 transportation but do not require ambulance service, as defined in section 144E.001,
333.22 subdivision 3. Special transportation service includes but is not limited to service provided
333.23 by specially equipped buses, vans, taxis, and volunteers driving private automobiles.
333.24 Special transportation service also means those nonemergency medical transportation
333.25 services under section 256B.0625, subdivision 17, that are subject to the operating
333.26 standards for special transportation service under sections 174.29 to 174.30 and Minnesota
333.27 Rules, chapter 8840.

333.28 **EFFECTIVE DATE.** This section is effective July 1, 2016.

333.29 Sec. 4. Minnesota Statutes 2014, section 174.30, subdivision 3, is amended to read:

333.30 Subd. 3. **Other standards; wheelchair securement; protected transport.** (a) A
333.31 special transportation service that transports individuals occupying wheelchairs is subject
333.32 to the provisions of sections 299A.11 to 299A.18 concerning wheelchair securement
333.33 devices. The commissioners of transportation and public safety shall cooperate in the
333.34 enforcement of this section and sections 299A.11 to 299A.18 so that a single inspection
334.1 is sufficient to ascertain compliance with sections 299A.11 to 299A.18 and with the
334.2 standards adopted under this section. Representatives of the Department of Transportation
334.3 may inspect wheelchair securement devices in vehicles operated by special transportation
334.4 service providers to determine compliance with sections 299A.11 to 299A.18 and to issue
334.5 certificates under section 299A.14, subdivision 4.

334.6 (b) In place of a certificate issued under section 299A.14, the commissioner may
334.7 issue a decal under subdivision 4 for a vehicle equipped with a wheelchair securement
334.8 device if the device complies with sections 299A.11 to 299A.18 and the decal displays the
334.9 information in section 299A.14, subdivision 4.

334.10 (c) For vehicles designated as protected transport under section 256B.0625,
334.11 subdivision 17, paragraph (h), the commissioner of transportation, during the
334.12 commissioner's inspection, shall check to ensure the safety provisions contained in that
334.13 paragraph are in working order.

334.14 **EFFECTIVE DATE.** This section is effective July 1, 2016.

334.15 Sec. 5. Minnesota Statutes 2014, section 174.30, subdivision 4, is amended to read:

334.16 Subd. 4. **Vehicle and equipment inspection; rules; decal; complaint contact**
334.17 **information; restrictions on name of service.** (a) The commissioner shall inspect or
334.18 provide for the inspection of vehicles at least annually. In addition to scheduled annual
334.19 inspections and reinspections scheduled for the purpose of verifying that deficiencies have
334.20 been corrected, unannounced inspections of any vehicle may be conducted.

334.21 (b) On determining that a vehicle or vehicle equipment is in a condition that is likely
334.22 to cause an accident or breakdown, the commissioner shall require the vehicle to be taken
334.23 out of service immediately. The commissioner shall require that vehicles and equipment
334.24 not meeting standards be repaired and brought into conformance with the standards
334.25 and shall require written evidence of compliance from the operator before allowing the
334.26 operator to return the vehicle to service.

334.27 (c) The commissioner shall provide in the rules procedures for inspecting vehicles,
334.28 removing unsafe vehicles from service, determining and requiring compliance, and
334.29 reviewing driver qualifications.

334.30 (d) The commissioner shall design a distinctive decal to be issued to special
334.31 transportation service providers with a current certificate of compliance under this section.
334.32 A decal is valid for one year from the last day of the month in which it is issued. A person
334.33 who is subject to the operating standards adopted under this section may not provide
334.34 special transportation service in a vehicle that does not conspicuously display a decal
334.35 issued by the commissioner.

335.1 (e) All special transportation service providers shall pay an annual fee of $45
335.2 to obtain a decal. Providers of ambulance service, as defined in section 144E.001,
335.3 subdivision 3, are exempt from the annual fee. Fees collected under this paragraph must
335.4 be deposited in the trunk highway fund, and are appropriated to the commissioner to pay
335.5 for costs related to administering the special transportation service program.

335.6 (f) Special transportation service providers shall prominently display in each vehicle
335.7 all contact information for the submission of complaints regarding the transportation
335.8 services provided to that individual. All vehicles providing service under section
335.9 473.386 shall display contact information for the Metropolitan Council. All other special
335.10 transportation service vehicles shall display contact information for the commissioner of
335.11 transportation.

335.12 (g) Nonemergency medical transportation providers must comply with Minnesota
335.13 Rules, part 8840.5450, except that a provider may use the phrase "nonemergency medical
335.14 transportation" in its name or in advertisements or information describing the service.

335.15 **EFFECTIVE DATE.** This section is effective July 1, 2016.

335.16 Sec. 6. Minnesota Statutes 2014, section 174.30, is amended by adding a subdivision
335.17 to read:

335.18 Subd. 4b. **Variance from the standards.** A nonemergency medical transportation
335.19 provider who was not subject to the standards in this section prior to July 1, 2014, must
335.20 apply for a variance from the commissioner if the provider cannot meet the standards
335.21 by January 1, 2017. The commissioner may grant or deny the variance application.
335.22 Variances, if granted, shall not exceed 60 days unless extended by the commissioner.

335.23 **EFFECTIVE DATE.** This section is effective July 1, 2016.

335.24 Sec. 7. Minnesota Statutes 2014, section 174.30, is amended by adding a subdivision
335.25 to read:

335.26 Subd. 10. **Background studies.** (a) Providers of special transportation service
335.27 regulated under this section must initiate background studies in accordance with chapter
335.28 245C on the following individuals:

335.29 (1) each person with a direct or indirect ownership interest of five percent or higher
335.30 in the transportation service provider;

335.31 (2) each controlling individual as defined under section 245A.02;

335.32 (3) managerial officials as defined in section 245A.02;

335.33 (4) each driver employed by the transportation service provider;

336.1 (5) each individual employed by the transportation service provider to assist a
336.2 passenger during transport; and

336.3 (6) all employees of the transportation service agency who provide administrative
336.4 support, including those who:

336.5 (i) may have face-to-face contact with or access to passengers, their personal
336.6 property, or their private data;

336.7 (ii) perform any scheduling or dispatching tasks; or

336.8 (iii) perform any billing activities.

336.9 (b) The transportation service provider must initiate the background studies required
336.10 under paragraph (a) using the online NETStudy system operated by the commissioner
336.11 of human services.

336.12 (c) The transportation service provider shall not permit any individual to provide
336.13 any service listed in paragraph (a) until the transportation service provider has received
336.14 notification from the commissioner of human services indicating that the individual:

336.15 (1) is not disqualified under chapter 245C; or

336.16 (2) is disqualified, but has received a set-aside of that disqualification according to
336.17 section 245C.23 related to that transportation service provider.

336.18 (d) When a local or contracted agency is authorizing a ride under section 256B.0625,
336.19 subdivision 17, by a volunteer driver, and the agency authorizing the ride has reason
336.20 to believe the volunteer driver has a history that would disqualify the individual or
336.21 that may pose a risk to the health or safety of passengers, the agency may initiate a
336.22 background study to be completed according to chapter 245C using the commissioner
336.23 of human services' online NETStudy system, or through contacting the Department of
336.24 Human Services background study division for assistance. The agency that initiates the
336.25 background study under this paragraph shall be responsible for providing the volunteer
336.26 driver with the privacy notice required under section 245C.05, subdivision 2c, and
336.27 payment for the background study required under section 245C.10, subdivision 11, before
336.28 the background study is completed.

336.29 **EFFECTIVE DATE.** This section is effective January 1, 2016.

336.30 Sec. 8. Minnesota Statutes 2014, section 245C.03, is amended by adding a subdivision
336.31 to read:

336.32 Subd. 10. **Providers of special transportation service.** The commissioner shall
336.33 conduct background studies on any individual required under section 174.30 to have a
336.34 background study completed under this chapter.

337.1 **EFFECTIVE DATE.** This section is effective January 1, 2016.

337.2 Sec. 9. Minnesota Statutes 2014, section 245C.10, is amended by adding a subdivision
337.3 to read:

337.4 Subd. 11. **Providers of special transportation service.** The commissioner shall
337.5 recover the cost of background studies initiated by providers of special transportation
337.6 service under section 174.30 through a fee of no more than $20 per study. The fees
337.7 collected under this subdivision are appropriated to the commissioner for the purpose of
337.8 conducting background studies.

337.9 **EFFECTIVE DATE.** This section is effective January 1, 2016.

337.10 Sec. 10. Minnesota Statutes 2014, section 256.015, subdivision 7, is amended to read:

337.11 Subd. 7. **Cooperation with information requests required.** (a) Upon the request
337.12 of the commissioner of human services:

337.13 (1) any state agency or third-party payer shall cooperate by furnishing information to
337.14 help establish a third-party liability, as required by the federal Deficit Reduction Act of
337.15 2005, Public Law 109-171;

337.16 (2) any employer or third-party payer shall cooperate by furnishing a data file
337.17 containing information about group health insurance plan or medical benefit plan coverage
337.18 of its employees or insureds within 60 days of the request. The information in the data file
337.19 must include at least the following: full name, date of birth, Social Security number if
337.20 collected and stored in a system routinely used for producing data files by the employer
337.21 or third-party payer, employer name, policy identification number, group identification
337.22 number, and plan or coverage type.

337.23 (b) For purposes of section 176.191, subdivision 4, the commissioner of labor and
337.24 industry may allow the commissioner of human services and county agencies direct access
337.25 and data matching on information relating to workers' compensation claims in order to
337.26 determine whether the claimant has reported the fact of a pending claim and the amount
337.27 paid to or on behalf of the claimant to the commissioner of human services.

337.28 (c) For the purpose of compliance with section 169.09, subdivision 13, and
337.29 federal requirements under Code of Federal Regulations, title 42, section 433.138
337.30 (d)(4), the commissioner of public safety shall provide accident data as requested by
337.31 the commissioner of human services. The disclosure shall not violate section 169.09,
337.32 subdivision 13, paragraph (d).

337.33 (d) The commissioner of human services and county agencies shall limit its use of
337.34 information gained from agencies, third-party payers, and employers to purposes directly
338.1 connected with the administration of its public assistance and child support programs. The
338.2 provision of information by agencies, third-party payers, and employers to the department
338.3 under this subdivision is not a violation of any right of confidentiality or data privacy.

338.4 Sec. 11. Minnesota Statutes 2014, section 256.969, subdivision 1, is amended to read:

338.5 Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change
338.6 in the Consumer Price Index-All Items (United States city average) (CPI-U) forecasted
338.7 by Data Resources, Inc. The commissioner shall use the indices as forecasted in the
338.8 third quarter of the calendar year prior to the rate year. The hospital cost index may be
338.9 used to adjust the base year operating payment rate through the rate year on an annually
338.10 compounded basis.

338.11 (b) For fiscal years beginning on or after July 1, 1993, the commissioner of human
338.12 services shall not provide automatic annual inflation adjustments for hospital payment
338.13 rates under medical assistance. ~~The commissioner of management and budget shall~~
338.14 ~~include as a budget change request in each biennial detailed expenditure budget submitted~~
338.15 ~~to the legislature under section 16A.11 annual adjustments in hospital payment rates under~~
338.16 ~~medical assistance based upon the hospital cost index.~~

338.17 Sec. 12. Minnesota Statutes 2014, section 256.969, subdivision 2b, is amended to read:

338.18 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after
338.19 November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be
338.20 paid according to the following:

7.14 Sec. 5. Minnesota Statutes 2014, section 256.969, subdivision 2b, is amended to read:

7.15 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after
7.16 November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be
7.17 paid according to the following:

Senate Language S1458-2

338.21 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based
338.22 methodology;

338.23 (2) long-term hospitals as defined by Medicare shall be paid on a per diem
338.24 methodology under subdivision 25;

338.25 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation
338.26 distinct parts as defined by Medicare shall be paid according to the methodology under
338.27 subdivision 12; and

338.28 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

338.29 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall
338.30 not be rebased, except that a Minnesota long-term hospital shall be rebased effective
338.31 January 1, 2011, based on its most recent Medicare cost report ending on or before
338.32 September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates
338.33 in effect on December 31, 2010. For rate setting periods after November 1, 2014, in
339.1 which the base years are updated, a Minnesota long-term hospital's base year shall remain
339.2 within the same period as other hospitals.

339.3 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
339.4 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
339.5 area, except for the hospitals paid under the methodologies described in paragraph (a),
339.6 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
339.7 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall
339.8 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring
339.9 that the total aggregate payments under the rebased system are equal to the total aggregate
339.10 payments that were made for the same number and types of services in the base year.
339.11 Separate budget neutrality calculations shall be determined for payments made to critical
339.12 access hospitals and payments made to hospitals paid under the DRG system. Only the rate
339.13 increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased
339.14 during the entire base period shall be incorporated into the budget neutrality calculation.

339.15 (d) For discharges occurring on or after November 1, 2014, through ~~June 30, 2016~~
339.16 the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals
339.17 under paragraph (a), clause (4), shall include adjustments to the projected rates that result
339.18 in no greater than a five percent increase or decrease from the base year payments for any
339.19 hospital. Any adjustments to the rates made by the commissioner under this paragraph and
339.20 paragraph (e) shall maintain budget neutrality as described in paragraph (c).

339.21 (e) For discharges occurring on or after November 1, 2014, through ~~June 30, 2016,~~
339.22 the next rebasing that occurs the commissioner may make additional adjustments to the
339.23 rebased rates, and when evaluating whether additional adjustments should be made, the
339.24 commissioner shall consider the impact of the rates on the following:

339.25 (1) pediatric services;

House Language UES1458-1

7.18 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based
7.19 methodology;

7.20 (2) long-term hospitals as defined by Medicare shall be paid on a per diem
7.21 methodology under subdivision 25;

7.22 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation
7.23 distinct parts as defined by Medicare shall be paid according to the methodology under
7.24 subdivision 12; and

7.25 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

7.26 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall
7.27 not be rebased, except that a Minnesota long-term hospital shall be rebased effective
7.28 January 1, 2011, based on its most recent Medicare cost report ending on or before
7.29 September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates
7.30 in effect on December 31, 2010. For rate setting periods after November 1, 2014, in
7.31 which the base years are updated, a Minnesota long-term hospital's base year shall remain
7.32 within the same period as other hospitals.

7.33 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
7.34 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
7.35 area, except for the hospitals paid under the methodologies described in paragraph (a),
8.1 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
8.2 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall
8.3 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring
8.4 that the total aggregate payments under the rebased system are equal to the total aggregate
8.5 payments that were made for the same number and types of services in the base year.
8.6 Separate budget neutrality calculations shall be determined for payments made to critical
8.7 access hospitals and payments made to hospitals paid under the DRG system. Only the rate
8.8 increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased
8.9 during the entire base period shall be incorporated into the budget neutrality calculation.

8.10 (d) For discharges occurring on or after November 1, 2014, through June 30, 2016,
8.11 the rebased rates under paragraph (c) shall include adjustments to the projected rates that
8.12 result in no greater than a five percent increase or decrease from the base year payments
8.13 for any hospital. Any adjustments to the rates made by the commissioner under this
8.14 paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

8.15 (e) For discharges occurring on or after November 1, 2014, through June 30, 2016,
8.16 the commissioner may make additional adjustments to the rebased rates, and when
8.17 evaluating whether additional adjustments should be made, the commissioner shall
8.18 consider the impact of the rates on the following:

8.19 (1) pediatric services;

339.26 (2) behavioral health services;

339.27 (3) trauma services as defined by the National Uniform Billing Committee;

339.28 (4) transplant services;

339.29 (5) obstetric services, newborn services, and behavioral health services provided
339.30 by hospitals outside the seven-county metropolitan area;

339.31 (6) outlier admissions;

339.32 (7) low-volume providers; and

339.33 (8) services provided by small rural hospitals that are not critical access hospitals.

339.34 (f) Hospital payment rates established under paragraph (c) must incorporate the
339.35 following:

340.1 (1) for hospitals paid under the DRG methodology, the base year payment rate per
340.2 admission is standardized by the applicable Medicare wage index and adjusted by the
340.3 hospital's disproportionate population adjustment;

340.4 (2) for critical access hospitals, interim per diem payment rates shall be based on the
340.5 ratio of cost and charges reported on the base year Medicare cost report or reports and
340.6 applied to medical assistance utilization data. Final settlement payments for a state fiscal
340.7 year must be determined based on a review of the medical assistance cost report required
340.8 under subdivision 4b for the applicable state fiscal year;

340.9 (3) the cost and charge data used to establish hospital payment rates must only
340.10 reflect inpatient services covered by medical assistance; and

340.11 (4) in determining hospital payment rates for discharges occurring on or after the
340.12 rate year beginning January 1, 2011, through December 31, 2012, the hospital payment
340.13 rate per discharge shall be based on the cost-finding methods and allowable costs of the
340.14 Medicare program in effect during the base year or years.

340.15 (g) The commissioner shall validate the rates effective November 1, 2014, by
340.16 applying the rates established under paragraph (c), and any adjustments made to the rates
340.17 under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine
340.18 whether the total aggregate payments for the same number and types of services under the
340.19 rebased rates are equal to the total aggregate payments made during calendar year 2013.

8.20 (2) behavioral health services;

8.21 (3) trauma services as defined by the National Uniform Billing Committee;

8.22 (4) transplant services;

8.23 (5) obstetric services, newborn services, and behavioral health services provided
8.24 by hospitals outside the seven-county metropolitan area;

8.25 (6) outlier admissions;

8.26 (7) low-volume providers; and

8.27 (8) services provided by small rural hospitals that are not critical access hospitals.

8.28 (f) Hospital payment rates established under paragraph (c) must incorporate the
8.29 following:

8.30 (1) for hospitals paid under the DRG methodology, the base year payment rate per
8.31 admission is standardized by the applicable Medicare wage index and adjusted by the
8.32 hospital's disproportionate population adjustment;

8.33 (2) for critical access hospitals, interim per diem payment rates shall be based on the
8.34 ratio of cost and charges reported on the base year Medicare cost report or reports and
8.35 applied to medical assistance utilization data. Final settlement payments for a state fiscal
9.1 year must be determined based on a review of the medical assistance cost report required
9.2 under subdivision 4b for the applicable state fiscal year;

9.3 (3) the cost and charge data used to establish hospital payment rates must only
9.4 reflect inpatient services covered by medical assistance; and

9.5 (4) in determining hospital payment rates for discharges occurring on or after the
9.6 rate year beginning January 1, 2011, through December 31, 2012, the hospital payment
9.7 rate per discharge shall be based on the cost-finding methods and allowable costs of the
9.8 Medicare program in effect during the base year or years.

9.9 (g) The commissioner shall validate the rates effective November 1, 2014, by
9.10 applying the rates established under paragraph (c), and any adjustments made to the rates
9.11 under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine
9.12 whether the total aggregate payments for the same number and types of services under the
9.13 rebased rates are equal to the total aggregate payments made during calendar year 2013.

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340.20 (h) Effective for discharges occurring on or after July 1, 2017, and every two
340.21 years thereafter, payment rates under this section shall be rebased to reflect only those
340.22 changes in hospital costs between the existing base year and the next base year. The
340.23 commissioner shall establish the base year for each rebasing period considering the most
340.24 recent year for which filed Medicare cost reports are available. The estimated change in
340.25 the average payment per hospital discharge resulting from a scheduled rebasing must be
340.26 calculated and made available to the legislature by January 15 of each year in which
340.27 rebasing is scheduled to occur, and must include by hospital the differential in payment
340.28 rates compared to the individual hospital's costs.

340.29 (i) Effective for discharges occurring on or after July 1, 2015, payment rates for
340.30 critical access hospitals located in Minnesota or the local trade area shall be determined
340.31 using a new cost-based methodology. The commissioner shall establish within the
340.32 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
340.33 Annual payments to hospitals under this paragraph shall equal the total cost for critical
340.34 access hospitals as reflected in base year cost reports, and until the next rebasing that
340.35 occurs, shall result in no greater than a five percent decrease from the base year payments
340.36 for any hospital. The new cost-based rate shall be the final rate and shall not be settled to
341.1 actual incurred costs. The factors used to develop the new methodology may include but
341.2 are not limited to:

341.3 (1) the ratio between the hospital's costs for treating medical assistance patients and
341.4 the hospital's charges to the medical assistance program;

341.5 (2) the ratio between the hospital's costs for treating medical assistance patients and
341.6 the hospital's payments received from the medical assistance program for the care of
341.7 medical assistance patients;

341.8 (3) the ratio between the hospital's charges to the medical assistance program and
341.9 the hospital's payments received from the medical assistance program for the care of
341.10 medical assistance patients;

341.11 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

341.12 (5) the proportion of that hospital's costs that are administrative and trends in
341.13 administrative costs; and

341.14 (6) geographic location.

341.15 Sec. 13. Minnesota Statutes 2014, section 256.969, subdivision 3a, is amended to read:

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9.14 (h) Effective for discharges occurring on or after July 1, 2017, and every two
9.15 years thereafter, payment rates under this section shall be rebased to reflect only those
9.16 changes in hospital costs between the existing base year and the next base year. The
9.17 commissioner shall establish the base year for each rebasing period considering the most
9.18 recent year for which filed Medicare cost reports are available. The estimated change in
9.19 the average payment per hospital discharge resulting from a scheduled rebasing must be
9.20 calculated and made available to the legislature by January 15 of each year in which
9.21 rebasing is scheduled to occur, and must include by hospital the differential in payment
9.22 rates compared to the individual hospital's costs.

9.23 (i) Effective for discharges occurring on or after July 1, 2015, payment rates for
9.24 critical access hospitals located in Minnesota or the local trade area shall be determined
9.25 using a new cost-based methodology. The commissioner shall establish within the
9.26 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
9.27 Annual payments to hospitals under this paragraph shall equal the total cost for critical
9.28 access hospitals as reflected in base year cost reports. The new cost-based rate shall be
9.29 the final rate and shall not be settled to actual incurred costs. The factors used to develop
9.30 the new methodology may include but are not limited to:

9.31 (1) the ratio between the hospital's costs for treating medical assistance patients and
9.32 the hospital's charges to the medical assistance program;

9.33 (2) the ratio between the hospital's costs for treating medical assistance patients and
9.34 the hospital's payments received from the medical assistance program for the care of
9.35 medical assistance patients;

10.1 (3) the ratio between the hospital's charges to the medical assistance program and
10.2 the hospital's payments received from the medical assistance program for the care of
10.3 medical assistance patients;

10.4 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

10.5 (5) the proportion of that hospital's costs that are administrative and trends in
10.6 administrative costs; and

10.7 (6) geographic location.

341.16 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance
341.17 program must not be submitted until the recipient is discharged. However, the
341.18 commissioner shall establish monthly interim payments for inpatient hospitals that have
341.19 individual patient lengths of stay over 30 days regardless of diagnostic category. Except
341.20 as provided in section 256.9693, medical assistance reimbursement for treatment of
341.21 mental illness shall be reimbursed based on diagnostic classifications. Individual hospital
341.22 payments established under this section and sections 256.9685, 256.9686, and 256.9695, in
341.23 addition to third-party and recipient liability, for discharges occurring during the rate year
341.24 shall not exceed, in aggregate, the charges for the medical assistance covered inpatient
341.25 services paid for the same period of time to the hospital. Services that have rates established
341.26 under subdivision 11 or 12, must be limited separately from other services. After
341.27 consulting with the affected hospitals, the commissioner may consider related hospitals
341.28 one entity and may merge the payment rates while maintaining separate provider numbers.
341.29 The operating and property base rates per admission or per day shall be derived from the
341.30 best Medicare and claims data available when rates are established. The commissioner
341.31 shall determine the best Medicare and claims data, taking into consideration variables of
341.32 recency of the data, audit disposition, settlement status, and the ability to set rates in a
341.33 timely manner. The commissioner shall notify hospitals of payment rates 30 days prior to
341.34 implementation. The rate setting data must reflect the admissions data used to establish
341.35 relative values. The commissioner may adjust base year cost, relative value, and case mix
342.1 index data to exclude the costs of services that have been discontinued by the October
342.2 1 of the year preceding the rate year or that are paid separately from inpatient services.
342.3 Inpatient stays that encompass portions of two or more rate years shall have payments
342.4 established based on payment rates in effect at the time of admission unless the date of
342.5 admission preceded the rate year in effect by six months or more. In this case, operating
342.6 payment rates for services rendered during the rate year in effect and established based on
342.7 the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

342.8 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total
342.9 payment, before third-party liability and spenddown, made to hospitals for inpatient
342.10 services is reduced by .5 percent from the current statutory rates.

342.11 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
342.12 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before
342.13 third-party liability and spenddown, is reduced five percent from the current statutory
342.14 rates. Mental health services within diagnosis related groups 424 to 432 or corresponding
342.15 APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph.

342.16 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
342.17 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
342.18 inpatient services before third-party liability and spenddown, is reduced 6.0 percent from
342.19 the current statutory rates. Mental health services within diagnosis related groups 424
342.20 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are
342.21 excluded from this paragraph. Payments made to managed care plans shall be reduced for
342.22 services provided on or after January 1, 2006, to reflect this reduction.

342.23 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
342.24 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
342.25 to hospitals for inpatient services before third-party liability and spenddown, is reduced
342.26 3.46 percent from the current statutory rates. Mental health services with diagnosis
342.27 related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under
342.28 subdivision 16 are excluded from this paragraph. Payments made to managed care plans
342.29 shall be reduced for services provided on or after January 1, 2009, through June 30, 2009,
342.30 to reflect this reduction.

342.31 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
342.32 for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011,
342.33 made to hospitals for inpatient services before third-party liability and spenddown, is
342.34 reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis
342.35 related groups 424 to 432 or corresponding APR-DRGs, and facilities defined under
342.36 subdivision 16 are excluded from this paragraph. Payments made to managed care plans
343.1 shall be reduced for services provided on or after July 1, 2009, through June 30, 2011,
343.2 to reflect this reduction.

343.3 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
343.4 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for
343.5 inpatient services before third-party liability and spenddown, is reduced 1.79 percent from
343.6 the current statutory rates. Mental health services with diagnosis related groups 424 to 432
343.7 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded
343.8 from this paragraph. Payments made to managed care plans shall be reduced for services
343.9 provided on or after July 1, 2011, to reflect this reduction.

343.10 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total
343.11 payment for fee-for-service admissions occurring on or after July 1, 2009, made to
343.12 hospitals for inpatient services before third-party liability and spenddown, is reduced
343.13 one percent from the current statutory rates. Facilities defined under subdivision 16 are
343.14 excluded from this paragraph. Payments made to managed care plans shall be reduced for
343.15 services provided on or after October 1, 2009, to reflect this reduction.

343.16 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total
343.17 payment for fee-for-service admissions occurring on or after July 1, 2011, made to
343.18 hospitals for inpatient services before third-party liability and spenddown, is reduced
343.19 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are
343.20 excluded from this paragraph. Payments made to managed care plans shall be reduced for
343.21 services provided on or after January 1, 2011, to reflect this reduction.

343.22 (j) Effective for discharges on and after November 1, 2014, from hospitals paid
343.23 under subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this
343.24 subdivision must be incorporated into the rebased rates established under subdivision 2b,
343.25 paragraph (c), and must not be applied to each claim.

343.26 (k) Effective for discharges on and after July 1, 2015, from hospitals paid under
343.27 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision
343.28 must be incorporated into the rates and must not be applied to each claim.

343.29 Sec. 14. Minnesota Statutes 2014, section 256.969, subdivision 3c, is amended to read:

343.30 Subd. 3c. **Rateable reduction and readmissions reduction.** (a) The total payment
343.31 for fee for service admissions occurring on or after September 1, 2011, to October 31,
343.32 2014, made to hospitals for inpatient services before third-party liability and spenddown,
343.33 is reduced ten percent from the current statutory rates. Facilities defined under subdivision
343.34 16, long-term hospitals as determined under the Medicare program, children's hospitals
344.1 whose inpatients are predominantly under 18 years of age, and payments under managed
344.2 care are excluded from this paragraph.

344.3 (b) Effective for admissions occurring during calendar year 2010 and each year
344.4 after, the commissioner shall calculate a readmission rate for admissions to all hospitals
344.5 occurring within 30 days of a previous discharge using data from the Reducing Avoidable
344.6 Readmissions Effectively (RARE) campaign. The commissioner may adjust the
344.7 readmission rate taking into account factors such as the medical relationship, complicating
344.8 conditions, and sequencing of treatment between the initial admission and subsequent
344.9 readmissions.

344.10 (c) Effective for payments to all hospitals on or after July 1, 2013, through October
344.11 31, 2014, the reduction in paragraph (a) is reduced one percentage point for every
344.12 percentage point reduction in the overall readmissions rate between the two previous
344.13 calendar years to a maximum of five percent.

344.14 (d) The exclusion from the rate reduction in paragraph (a) shall apply to a hospital
344.15 located in Hennepin County with a licensed capacity of 1,700 beds as of September 1,
344.16 2011, for admissions of children under 18 years of age occurring on or after September 1,
344.17 2011, through August 31, 2013, but shall not apply to payments for admissions occurring
344.18 on or after September 1, 2013, through October 31, 2014.

344.19 (e) Effective for discharges on or after November 1, 2014, from hospitals paid under
344.20 subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision
344.21 must be incorporated into the rebased rates established under subdivision 2b, paragraph
344.22 (c), and must not be applied to each claim.

344.23 (f) Effective for discharges on and after July 1, 2015, from hospitals paid under
344.24 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision
344.25 must be incorporated into the rates and must not be applied to each claim.

344.26 Sec. 15. Minnesota Statutes 2014, section 256.969, subdivision 9, is amended to read:

344.27 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For
344.28 admissions occurring on or after July 1, 1993, the medical assistance disproportionate
344.29 population adjustment shall comply with federal law and shall be paid to a hospital,
344.30 excluding regional treatment centers and facilities of the federal Indian Health Service,
344.31 with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The
344.32 adjustment must be determined as follows:

344.33 (1) for a hospital with a medical assistance inpatient utilization rate above the
344.34 arithmetic mean for all hospitals excluding regional treatment centers and facilities of the
344.35 federal Indian Health Service but less than or equal to one standard deviation above the
345.1 mean, the adjustment must be determined by multiplying the total of the operating and
345.2 property payment rates by the difference between the hospital's actual medical assistance
345.3 inpatient utilization rate and the arithmetic mean for all hospitals excluding regional
345.4 treatment centers and facilities of the federal Indian Health Service; and

345.5 (2) for a hospital with a medical assistance inpatient utilization rate above one
345.6 standard deviation above the mean, the adjustment must be determined by multiplying
345.7 the adjustment that would be determined under clause (1) for that hospital by 1.1.
345.8 ~~The commissioner may establish a separate disproportionate population payment rate~~
345.9 ~~adjustment for critical access hospitals.~~ The commissioner shall report annually on the
345.10 number of hospitals likely to receive the adjustment authorized by this paragraph. The
345.11 commissioner shall specifically report on the adjustments received by public hospitals and
345.12 public hospital corporations located in cities of the first class.

345.13 (b) Certified public expenditures made by Hennepin County Medical Center shall
345.14 be considered Medicaid disproportionate share hospital payments. Hennepin County
345.15 and Hennepin County Medical Center shall report by June 15, 2007, on payments made
345.16 beginning July 1, 2005, or another date specified by the commissioner, that may qualify
345.17 for reimbursement under federal law. Based on these reports, the commissioner shall
345.18 apply for federal matching funds.

345.19 (c) Upon federal approval of the related state plan amendment, paragraph (b) is
345.20 effective retroactively from July 1, 2005, or the earliest effective date approved by the
345.21 Centers for Medicare and Medicaid Services.

10.8 Sec. 6. Minnesota Statutes 2014, section 256.969, subdivision 9, is amended to read:

10.9 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For
10.10 admissions occurring on or after July 1, 1993, the medical assistance disproportionate
10.11 population adjustment shall comply with federal law and shall be paid to a hospital,
10.12 excluding regional treatment centers and facilities of the federal Indian Health Service,
10.13 with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The
10.14 adjustment must be determined as follows:

10.15 (1) for a hospital with a medical assistance inpatient utilization rate above the
10.16 arithmetic mean for all hospitals excluding regional treatment centers and facilities of the
10.17 federal Indian Health Service but less than or equal to one standard deviation above the
10.18 mean, the adjustment must be determined by multiplying the total of the operating and
10.19 property payment rates by the difference between the hospital's actual medical assistance
10.20 inpatient utilization rate and the arithmetic mean for all hospitals excluding regional
10.21 treatment centers and facilities of the federal Indian Health Service; and

10.22 (2) for a hospital with a medical assistance inpatient utilization rate above one
10.23 standard deviation above the mean, the adjustment must be determined by multiplying
10.24 the adjustment that would be determined under clause (1) for that hospital by 1.1.
10.25 The commissioner may establish a separate disproportionate population payment rate
10.26 adjustment for critical access hospitals. The commissioner shall report annually on the
10.27 number of hospitals likely to receive the adjustment authorized by this paragraph. The
10.28 commissioner shall specifically report on the adjustments received by public hospitals and
10.29 public hospital corporations located in cities of the first class.

10.30 (b) Certified public expenditures made by Hennepin County Medical Center shall
10.31 be considered Medicaid disproportionate share hospital payments. Hennepin County
10.32 and Hennepin County Medical Center shall report by June 15, 2007, on payments made
10.33 beginning July 1, 2005, or another date specified by the commissioner, that may qualify
10.34 for reimbursement under federal law. Based on these reports, the commissioner shall
10.35 apply for federal matching funds.

11.1 (c) Upon federal approval of the related state plan amendment, paragraph (b) is
11.2 effective retroactively from July 1, 2005, or the earliest effective date approved by the
11.3 Centers for Medicare and Medicaid Services.

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345.22 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall
345.23 be paid in accordance with a new methodology. Annual DSH payments made under
345.24 this paragraph shall equal the total amount of DSH payments made for 2012. The new
345.25 methodology shall take into account a variety of factors, including but not limited to:

345.26 (1) the medical assistance utilization rate of the hospitals that receive payments
345.27 under this subdivision;

345.28 (2) whether the hospital is located within Minnesota;

345.29 (3) the hospital's status as a safety net, critical access, children's, rehabilitation, or
345.30 long-term hospital;

345.31 (4) whether the hospital's administrative cost of compiling the necessary DSH
345.32 reports exceeds the anticipated value of any calculated DSH payment; and

345.33 (5) whether the hospital provides specific services designated by the commissioner
345.34 to be of particular importance to the medical assistance program.

345.35 (e) Any payments or portion of payments made to a hospital under this subdivision
345.36 that are subsequently returned to the commissioner because the payments are found to
346.1 exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate
346.2 to the number of fee-for-service discharges, to other DSH-eligible nonchildren's hospitals
346.3 that have a medical assistance utilization rate that is at least one standard deviation above
346.4 the mean.

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11.4 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall
11.5 be paid in accordance with a new methodology. Annual DSH payments made under
11.6 this paragraph shall equal the total amount of DSH payments made for 2012. The new
11.7 methodology shall take into account a variety of factors, including but not limited to:

11.8 (1) the medical assistance utilization rate of the hospitals that receive payments
11.9 under this subdivision;

11.10 (2) whether the hospital is located within Minnesota;

11.11 (3) the difference between a hospital's costs for treating medical assistance patients
11.12 and the total amount of payments received from medical assistance;

11.13 (4) the percentage of uninsured patient days at each qualifying hospital in relation
11.14 to the total number of uninsured patient days statewide;

11.15 (5) the hospital's status as a hospital authorized to make presumptive eligibility
11.16 determinations for medical assistance in accordance with section 256B.057, subdivision 12;

11.17 (6) the hospital's status as a safety net, critical access, children's, rehabilitation, or
11.18 long-term hospital;

11.19 (7) whether the hospital's administrative cost of compiling the necessary DSH
11.20 reports exceeds the anticipated value of any calculated DSH payment; and

11.21 (8) whether the hospital provides specific services designated by the commissioner
11.22 to be of particular importance to the medical assistance program.

11.23 (e) Any payments or portion of payments made to a hospital under this subdivision
11.24 that are subsequently returned to the commissioner because the payments are found to
11.25 exceed the hospital-specific DSH limit for that hospital shall be redistributed to other
11.26 DSH-eligible hospitals in a manner established by the commissioner.

ARTICLE 1, SECTION 7 MOVED TO CONTINUING CARE, SENATE ARTICLE 6/HOUSE ARTICLE 4.

54.27 Section 1. Minnesota Statutes 2014, section 256.98, subdivision 1, is amended to read:

54.28 Subdivision 1. **Wrongfully obtaining assistance.** A person who commits any of
54.29 the following acts or omissions with intent to defeat the purposes of sections 145.891
54.30 to 145.897, the MFIP program formerly codified in sections 256.031 to 256.0361, the
54.31 AFDC program formerly codified in sections 256.72 to 256.871, chapters 256B, 256D,
54.32 256J, 256K, or 256L, and child care assistance programs, is guilty of theft and shall be
54.33 sentenced under section 609.52, subdivision 3, clauses (1) to (5):

55.1 (1) obtains or attempts to obtain, or aids or abets any person to obtain by means of
55.2 a willfully false statement or representation, by intentional concealment of any material
55.3 fact, or by impersonation or other fraudulent device, assistance or the continued receipt of
55.4 assistance, to include child care assistance or vouchers produced according to sections
55.5 145.891 to 145.897 and ~~MinnesotaCare services according to sections~~ premium assistance
55.6 under section 256.9365~~, 256.94, and 256L.01 to 256L.15~~, to which the person is not
55.7 entitled or assistance greater than that to which the person is entitled;

55.8 (2) knowingly aids or abets in buying or in any way disposing of the property of a
55.9 recipient or applicant of assistance without the consent of the county agency; or

55.10 (3) obtains or attempts to obtain, alone or in collusion with others, the receipt of
55.11 payments to which the individual is not entitled as a provider of subsidized child care, or
55.12 by furnishing or concurring in a willfully false claim for child care assistance.

55.13 The continued receipt of assistance to which the person is not entitled or greater
55.14 than that to which the person is entitled as a result of any of the acts, failure to act, or
55.15 concealment described in this subdivision shall be deemed to be continuing offenses from
55.16 the date that the first act or failure to act occurred.

55.17 **EFFECTIVE DATE.** This section is effective January 1, 2016.

55.18 Sec. 2. Minnesota Statutes 2014, section 256B.021, subdivision 4, is amended to read:

55.19 Subd. 4. **Projects.** The commissioner shall request permission and funding to
55.20 further the following initiatives.

55.21 (a) Health care delivery demonstration projects. This project involves testing
55.22 alternative payment and service delivery models in accordance with sections 256B.0755
55.23 and 256B.0756. These demonstrations will allow the Minnesota Department of Human
55.24 Services to engage in alternative payment arrangements with provider organizations that
55.25 provide services to a specified patient population for an agreed upon total cost of care or
55.26 risk/gain sharing payment arrangement, but are not limited to these models of care delivery
55.27 or payment. Quality of care and patient experience will be measured and incorporated into
55.28 payment models alongside the cost of care. Demonstration sites should include Minnesota
55.29 health care programs fee-for-services recipients and managed care enrollees and support a
55.30 robust primary care model and improved care coordination for recipients.

55.31 (b) Promote personal responsibility and encourage and reward healthy outcomes.
55.32 This project provides Medicaid funding to provide individual and group incentives to
55.33 encourage healthy behavior, prevent the onset of chronic disease, and reward healthy
55.34 outcomes. Focus areas may include diabetes prevention and management, tobacco
55.35 cessation, reducing weight, lowering cholesterol, and lowering blood pressure.

56.1 (c) Encourage utilization of high quality, cost-effective care. This project creates
56.2 incentives through Medicaid and MinnesotaCare enrollee cost-sharing and other means to
56.3 encourage the utilization of high-quality, low-cost, high-value providers, as determined by
56.4 the state's provider peer grouping initiative under section 62U.04.

56.5 (d) Adults without children. This proposal includes requesting federal authority to
56.6 impose a limit on assets for adults without children in medical assistance, as defined in
56.7 section 256B.055, subdivision 15, who have a household income equal to or less than
56.8 75 percent of the federal poverty limit~~, and to impose a 180-day durational residency~~
56.9 ~~requirement in MinnesotaCare, consistent with section 256L.09, subdivision 4, for adults~~
56.10 ~~without children, regardless of income~~.

56.11 (e) Empower and encourage work, housing, and independence. This project provides
56.12 services and supports for individuals who have an identified health or disabling condition
56.13 but are not yet certified as disabled, in order to delay or prevent permanent disability,
56.14 reduce the need for intensive health care and long-term care services and supports, and to
56.15 help maintain or obtain employment or assist in return to work. Benefits may include:

56.16 (1) coordination with health care homes or health care coordinators;

56.17 (2) assessment for wellness, housing needs, employment, planning, and goal setting;

56.18 (3) training services;

56.19 (4) job placement services;

56.20 (5) career counseling;

56.21 (6) benefit counseling;

56.22 (7) worker supports and coaching;

56.23 (8) assessment of workplace accommodations;

56.24 (9) transitional housing services; and

56.25 (10) assistance in maintaining housing.

56.26 (f) Redesign home and community-based services. This project realigns existing
56.27 funding, services, and supports for people with disabilities and older Minnesotans to
56.28 ensure community integration and a more sustainable service system. This may involve
56.29 changes that promote a range of services to flexibly respond to the following needs:

56.30 (1) provide people less expensive alternatives to medical assistance services;

56.31 (2) offer more flexible and updated community support services under the Medicaid
56.32 state plan;

56.33 (3) provide an individual budget and increased opportunity for self-direction;

56.34 (4) strengthen family and caregiver support services;

56.35 (5) allow persons to pool resources or save funds beyond a fiscal year to cover
56.36 unexpected needs or foster development of needed services;

57.1 (6) use of home and community-based waiver programs for people whose needs
57.2 cannot be met with the expanded Medicaid state plan community support service options;

57.3 (7) target access to residential care for those with higher needs;

57.4 (8) develop capacity within the community for crisis intervention and prevention;

57.5 (9) redesign case management;

57.6 (10) offer life planning services for families to plan for the future of their child
57.7 with a disability;

57.8 (11) enhance self-advocacy and life planning for people with disabilities;

57.9 (12) improve information and assistance to inform long-term care decisions; and

57.10 (13) increase quality assurance, performance measurement, and outcome-based
57.11 reimbursement.

57.12 This project may include different levels of long-term supports that allow seniors to
57.13 remain in their homes and communities, and expand care transitions from acute care to
57.14 community care to prevent hospitalizations and nursing home placement. The levels
57.15 of support for seniors may range from basic community services for those with lower
57.16 needs, access to residential services if a person has higher needs, and targets access to
57.17 nursing home care to those with rehabilitation or high medical needs. This may involve
57.18 the establishment of medical need thresholds to accommodate the level of support
57.19 needed; provision of a long-term care consultation to persons seeking residential services,
57.20 regardless of payer source; adjustment of incentives to providers and care coordination
57.21 organizations to achieve desired outcomes; and a required coordination with medical
57.22 assistance basic care benefit and Medicare/Medigap benefit. This proposal will improve
57.23 access to housing and improve capacity to maintain individuals in their existing home;
57.24 adjust screening and assessment tools, as needed; improve transition and relocation
57.25 efforts; seek federal financial participation for alternative care and essential community
57.26 supports; and provide Medigap coverage for people having lower needs.

57.27 (g) Coordinate and streamline services for people with complex needs, including
57.28 those with multiple diagnoses of physical, mental, and developmental conditions. This
57.29 project will coordinate and streamline medical assistance benefits for people with complex
57.30 needs and multiple diagnoses. It would include changes that:

57.31 (1) develop community-based service provider capacity to serve the needs of this
57.32 group;

57.33 (2) build assessment and care coordination expertise specific to people with multiple
57.34 diagnoses;

57.35 (3) adopt service delivery models that allow coordinated access to a range of services
57.36 for people with complex needs;

58.1 (4) reduce administrative complexity;

58.2 (5) measure the improvements in the state's ability to respond to the needs of this
58.3 population; and

58.4 (6) increase the cost-effectiveness for the state budget.

58.5 (h) Implement nursing home level of care criteria. This project involves obtaining
58.6 any necessary federal approval in order to implement the changes to the level of care
58.7 criteria in section 144.0724, subdivision 11, and implement further changes necessary to
58.8 achieve reform of the home and community-based service system.

58.9 (i) Improve integration of Medicare and Medicaid. This project involves reducing
58.10 fragmentation in the health care delivery system to improve care for people eligible for
58.11 both Medicare and Medicaid, and to align fiscal incentives between primary, acute, and
58.12 long-term care. The proposal may include:

58.13 (1) requesting an exception to the new Medicare methodology for payment
58.14 adjustment for fully integrated special needs plans for dual eligible individuals;

58.15 (2) testing risk adjustment models that may be more favorable to capturing the
58.16 needs of frail dually eligible individuals;

58.17 (3) requesting an exemption from the Medicare bidding process for fully integrated
58.18 special needs plans for the dually eligible;

58.19 (4) modifying the Medicare bid process to recognize additional costs of health
58.20 home services; and

58.21 (5) requesting permission for risk-sharing and gain-sharing.

58.22 (j) Intensive residential treatment services. This project would involve providing
58.23 intensive residential treatment services for individuals who have serious mental illness
58.24 and who have other complex needs. This proposal would allow such individuals to remain
58.25 in these settings after mental health symptoms have stabilized, in order to maintain their
58.26 mental health and avoid more costly or unnecessary hospital or other residential care due
58.27 to their other complex conditions. The commissioner may pursue a specialized rate for
58.28 projects created under this section.

58.29 (k) Seek federal Medicaid matching funds for Anoka Metro Regional Treatment
58.30 Center (AMRTC). This project involves seeking Medicaid reimbursement for medical
58.31 services provided to patients to AMRTC, including requesting a waiver of United States
58.32 Code, title 42, section 1396d, which prohibits Medicaid reimbursement for expenditures
58.33 for services provided by hospitals with more than 16 beds that are primarily focused on
58.34 the treatment of mental illness. This waiver would allow AMRTC to serve as a statewide
58.35 resource to provide diagnostics and treatment for people with the most complex conditions.

59.1 (l) Waivers to allow Medicaid eligibility for children under age 21 receiving care
59.2 in residential facilities. This proposal would seek Medicaid reimbursement for any
59.3 Medicaid-covered service for children who are placed in residential settings that are
59.4 determined to be "institutions for mental diseases," under United States Code, title 42,
59.5 section 1396d.

59.6 **EFFECTIVE DATE.** This section is effective January 1, 2016.

346.5 Sec. 16. Minnesota Statutes 2014, section 256B.06, is amended by adding a
346.6 subdivision to read:

346.7 Subd. 6. **Legal referral and assistance grants.** (a) The commissioner shall award
346.8 grants to one or more nonprofit programs that provide legal services based on indigency to
346.9 provide legal services to individuals with emergency medical conditions or chronic health
346.10 conditions who are not currently eligible for medical assistance or other public health
346.11 care programs based on their legal status, but who may meet eligibility requirements
346.12 with legal assistance.

346.13 (b) The grantees, in collaboration with hospitals and safety net providers, shall
346.14 provide referral assistance to connect individuals identified in paragraph (a) with
346.15 alternative resources and services to assist in meeting their health care needs.

346.16 Sec. 17. Minnesota Statutes 2014, section 256B.0625, subdivision 9, is amended to read:

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

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

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

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

346.22 (3) limited exams;

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

346.24 (5) periapical x-rays;

346.25 (6) panoramic x-rays or full-mouth series of x-rays , limited to ~~one~~ once every five
346.26 years except (1) when medically necessary for the diagnosis and follow-up of oral and
346.27 maxillofacial pathology and trauma or (2) once every two years for patients who cannot
346.28 cooperate for intraoral film due to a developmental disability or medical condition that
346.29 does not allow for intraoral film placement;

346.30 (7) prophylaxis, limited to one per year;

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

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

346.33 (10) anterior fillings;

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

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

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

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

347.5 (15) full-mouth debridement, limited to one every five years; and

347.6 (16) nonsurgical treatment for periodontal disease, including scaling, root planing,
347.7 and routine periodontal maintenance procedures, limited to once per quadrant per year.

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

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

347.13 (2) general anesthesia; and

347.14 ~~(3) full-mouth survey once every five years~~

347.15 (3) a comprehensive oral examination and full-mouth series of x-rays.

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

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

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

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

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

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347.23 (e) In addition to the services specified in paragraphs (b) and (c), medical assistance
347.24 covers the following services for adults:

347.25 (1) house calls or extended care facility calls for on-site delivery of covered services;

347.26 (2) behavioral management when additional staff time is required to accommodate
347.27 behavioral challenges and sedation is not used;

347.28 (3) oral or IV sedation, if the covered dental service cannot be performed safely
347.29 without it or would otherwise require the service to be performed under general anesthesia
347.30 in a hospital or surgical center; and

347.31 (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but
347.32 no more than four times per year.

347.33 (f) The commissioner shall not require prior authorization for the services included
347.34 in paragraph (e), clauses (1) to (3), and shall prohibit managed care and county-based
347.35 purchasing plans from requiring prior authorization for the services included in paragraph
347.36 (e), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

348.1 Sec. 18. Minnesota Statutes 2014, section 256B.0625, is amended by adding a
348.2 subdivision to read:

348.3 Subd. 9b. **Dental services provided by faculty members and resident dentists**
348.4 **at a dental school.** (a) A dentist who is not enrolled as a medical assistance provider,
348.5 is a faculty or adjunct member at the University of Minnesota or a resident dentist
348.6 licensed under section 150A.06, subdivision 1b, and is providing dental services at a
348.7 dental clinic owned or operated by the University of Minnesota, may be enrolled as a
348.8 medical assistance provider if the provider completes and submits to the commissioner an
348.9 agreement form developed by the commissioner. The agreement must specify that the
348.10 faculty or adjunct member or resident dentist:

348.11 (1) will not receive payment for the services provided to medical assistance or
348.12 MinnesotaCare enrollees performed at the dental clinics owned or operated by the
348.13 University of Minnesota;

348.14 (2) will not be listed in the medical assistance or MinnesotaCare provider directory;
348.15 and

348.16 (3) is not required to serve medical assistance and MinnesotaCare enrollees when
348.17 providing nonvolunteer services in a private practice.

348.18 (b) A dentist or resident dentist enrolled under this subdivision as a fee-for-service
348.19 provider shall not otherwise be enrolled in or receive payments from medical assistance or
348.20 MinnesotaCare as a fee-for-service provider.

348.21 Sec. 19. Minnesota Statutes 2014, section 256B.0625, is amended by adding a
348.22 subdivision to read:

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12.1 Sec. 8. Minnesota Statutes 2014, section 256B.0625, is amended by adding a
12.2 subdivision to read:

12.3 Subd. 9b. **Dental services provided by faculty members and resident dentists**
12.4 **at a dental school.** (a) A dentist who is not enrolled as a medical assistance provider,
12.5 is a faculty or adjunct member at the University of Minnesota or a resident dentist
12.6 licensed under section 150A.06, subdivision 1b, and is providing dental services at a
12.7 dental clinic owned or operated by the University of Minnesota, may be enrolled as a
12.8 medical assistance provider if the provider completes and submits to the commissioner an
12.9 agreement form developed by the commissioner. The agreement must specify that the
12.10 faculty or adjunct member or resident dentist:

12.11 (1) will not receive payment for the services provided to medical assistance or
12.12 MinnesotaCare enrollees performed at the dental clinics owned or operated by the
12.13 University of Minnesota;

12.14 (2) will not be listed in the medical assistance or MinnesotaCare provider directory;
12.15 and

12.16 (3) is not required to serve medical assistance and MinnesotaCare enrollees when
12.17 providing nonvolunteer services in a private practice.

12.18 (b) A dentist or resident dentist enrolled under this subdivision as a fee-for-service
12.19 provider shall not otherwise be enrolled in or receive payments from medical assistance or
12.20 MinnesotaCare as a fee-for-service provider.

348.23 Subd. 9c. **Prior authorization for dental services.** Effective for dental services
348.24 rendered on or after January 1, 2016, the following prior authorization requirements
348.25 shall apply for services provided under fee-for-service or through a managed care plan
348.26 or county-based purchasing plan:

348.27 (1) prior authorization for a dental service shall remain valid for at least 12 months;

348.28 (2) a new prior authorization for a dental service shall not be required if a prior
348.29 authorization for the service has already been provided within the previous 12 months
348.30 for the same enrollee, if the enrollee changes health plans within the 12-month period in
348.31 which the prior authorization is valid; and

348.32 (3) a managed care plan or county-based purchasing plan shall not require prior
348.33 authorization before providing dental services to an enrollee that is more restrictive
348.34 than the prior authorization requirements established by the commissioner for the
348.35 fee-for-service system.

349.1 Sec. 20. Minnesota Statutes 2014, section 256B.0625, is amended by adding a
349.2 subdivision to read:

349.3 Subd. 9d. **Administrative simplification for dental services.** By January 1,
349.4 2016, the commissioner shall designate a uniform application form to be used in the
349.5 credentialing of all dental providers serving persons enrolled in medical assistance and
349.6 MinnesotaCare. The uniform application shall be developed by the commissioner in
349.7 consultation with representatives of managed care plans, county-based purchasing plans,
349.8 dental benefit administrators, and dental providers, and must meet the National Committee
349.9 for Quality Assurance accreditation standards related to credentialing.

ARTICLE 1, SECTIONS 9 AND 10 MOVED TO HEALTH CARE DELIVERY, SENATE ARTICLE 8/HOUSE ARTICLE 6.

349.10 Sec. 21. Minnesota Statutes 2014, section 256B.0625, subdivision 13h, is amended to
349.11 read:

17.1 Sec. 11. Minnesota Statutes 2014, section 256B.0625, subdivision 13h, is amended to
17.2 read:

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349.12 Subd. 13h. **Medication therapy management services.** (a) Medical assistance ~~and~~
349.13 ~~general assistance medical care cover~~ covers medication therapy management services
349.14 for a recipient taking ~~three or more~~ prescriptions to treat or prevent one or more chronic
349.15 medical conditions~~; a recipient with a drug therapy problem that is identified by the~~
349.16 ~~commissioner or identified by a pharmacist and approved by the commissioner; or prior~~
349.17 ~~authorized by the commissioner that has resulted or is likely to result in significant~~
349.18 ~~nondrug program costs. The commissioner may cover medical therapy management~~
349.19 ~~services under MinnesotaCare if the commissioner determines this is cost-effective~~. For
349.20 purposes of this subdivision, "medication therapy management" means the provision
349.21 of the following pharmaceutical care services by a licensed pharmacist to optimize the
349.22 therapeutic outcomes of the patient's medications:

349.23 (1) performing or obtaining necessary assessments of the patient's health status;

349.24 (2) formulating a medication treatment plan;

349.25 (3) monitoring and evaluating the patient's response to therapy, including safety
349.26 and effectiveness;

349.27 (4) performing a comprehensive medication review to identify, resolve, and prevent
349.28 medication-related problems, including adverse drug events;

349.29 (5) documenting the care delivered and communicating essential information to
349.30 the patient's other primary care providers;

349.31 (6) providing verbal education and training designed to enhance patient
349.32 understanding and appropriate use of the patient's medications;

349.33 (7) providing information, support services, and resources designed to enhance
349.34 patient adherence with the patient's therapeutic regimens; and

350.1 (8) coordinating and integrating medication therapy management services within the
350.2 broader health care management services being provided to the patient.

350.3 Nothing in this subdivision shall be construed to expand or modify the scope of practice of
350.4 the pharmacist as defined in section 151.01, subdivision 27.

350.5 (b) To be eligible for reimbursement for services under this subdivision, a pharmacist
350.6 must meet the following requirements:

350.7 (1) have a valid license issued by the Board of Pharmacy of the state in which the
350.8 medication therapy management service is being performed;

350.9 (2) have graduated from an accredited college of pharmacy on or after May 1996, or
350.10 completed a structured and comprehensive education program approved by the Board of
350.11 Pharmacy and the American Council of Pharmaceutical Education for the provision and
350.12 documentation of pharmaceutical care management services that has both clinical and
350.13 didactic elements;

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17.3 Subd. 13h. **Medication therapy management services.** (a) Medical assistance ~~and~~
17.4 ~~general assistance medical care cover~~ covers medication therapy management services
17.5 for a recipient taking ~~three or more~~ prescriptions to treat or prevent one or more chronic
17.6 medical conditions~~; a recipient with a drug therapy problem that is identified by the~~
17.7 ~~commissioner or identified by a pharmacist and approved by the commissioner; or prior~~
17.8 ~~authorized by the commissioner that has resulted or is likely to result in significant~~
17.9 ~~nondrug program costs. The commissioner may cover medical therapy management~~
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17.13 therapeutic outcomes of the patient's medications:

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17.16 (3) monitoring and evaluating the patient's response to therapy, including safety
17.17 and effectiveness;

17.18 (4) performing a comprehensive medication review to identify, resolve, and prevent
17.19 medication-related problems, including adverse drug events;

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17.21 the patient's other primary care providers;

17.22 (6) providing verbal education and training designed to enhance patient
17.23 understanding and appropriate use of the patient's medications;

17.24 (7) providing information, support services, and resources designed to enhance
17.25 patient adherence with the patient's therapeutic regimens; and

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17.27 broader health care management services being provided to the patient.

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17.29 the pharmacist as defined in section 151.01, subdivision 27.

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17.31 must meet the following requirements:

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17.33 medication therapy management service is being performed;

17.34 (2) have graduated from an accredited college of pharmacy on or after May 1996, or
17.35 completed a structured and comprehensive education program approved by the Board of
17.36 Pharmacy and the American Council of Pharmaceutical Education for the provision and
18.1 documentation of pharmaceutical care management services that has both clinical and
18.2 didactic elements;

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350.14 (3) be practicing in an ambulatory care setting as part of a multidisciplinary team or
350.15 have developed a structured patient care process that is offered in a private or semiprivate
350.16 patient care area that is separate from the commercial business that also occurs in the
350.17 setting, or in home settings, including long-term care settings, group homes, and facilities
350.18 providing assisted living services, but excluding skilled nursing facilities; and

350.19 (4) make use of an electronic patient record system that meets state standards.

350.20 (c) For purposes of reimbursement for medication therapy management services,
350.21 the commissioner may enroll individual pharmacists as medical assistance ~~and general~~
350.22 ~~assistance medical care~~ providers. The commissioner may also establish contact
350.23 requirements between the pharmacist and recipient, including limiting the number of
350.24 reimbursable consultations per recipient.

350.25 (d) If there are no pharmacists who meet the requirements of paragraph (b) practicing
350.26 within a reasonable geographic distance of the patient, a pharmacist who meets the
350.27 requirements may provide the services via two-way interactive video. Reimbursement
350.28 shall be at the same rates and under the same conditions that would otherwise apply to
350.29 the services provided. To qualify for reimbursement under this paragraph, the pharmacist
350.30 providing the services must meet the requirements of paragraph (b), and must be
350.31 located within an ambulatory care setting ~~approved by the commissioner~~ that meets the
350.32 requirements of paragraph (b), clause (3). The patient must also be located within an
350.33 ambulatory care setting ~~approved by the commissioner~~ that meets the requirements of
350.34 paragraph (b), clause (3). Services provided under this paragraph may not be transmitted
350.35 into the patient's residence.

351.1 ~~(e) The commissioner shall establish a pilot project for an intensive medication~~
351.2 ~~therapy management program for patients identified by the commissioner with multiple~~
351.3 ~~chronic conditions and a high number of medications who are at high risk of preventable~~
351.4 ~~hospitalizations, emergency room use, medication complications, and suboptimal~~
351.5 ~~treatment outcomes due to medication-related problems. For purposes of the pilot~~
351.6 ~~project, medication therapy management services may be provided in a patient's home~~
351.7 ~~or community setting, in addition to other authorized settings. The commissioner may~~
351.8 ~~waive existing payment policies and establish special payment rates for the pilot project.~~
351.9 ~~The pilot project must be designed to produce a net savings to the state compared to the~~
351.10 ~~estimated costs that would otherwise be incurred for similar patients without the program.~~
351.11 ~~The pilot project must begin by January 1, 2010, and end June 30, 2012.~~

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18.3 (3) be practicing in an ambulatory care setting as part of a multidisciplinary team or
18.4 have developed a structured patient care process that is offered in a private or semiprivate
18.5 patient care area that is separate from the commercial business that also occurs in the
18.6 setting, or in home settings, including long-term care settings, group homes, and facilities
18.7 providing assisted living services, but excluding skilled nursing facilities; and

18.8 (4) make use of an electronic patient record system that meets state standards.

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18.11 ~~assistance medical care~~ providers. The commissioner may also establish contact
18.12 requirements between the pharmacist and recipient, including limiting the number of
18.13 reimbursable consultations per recipient.

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18.15 within a reasonable geographic distance of the patient, a pharmacist who meets the
18.16 requirements may provide the services via two-way interactive video. Reimbursement
18.17 shall be at the same rates and under the same conditions that would otherwise apply to
18.18 the services provided. To qualify for reimbursement under this paragraph, the pharmacist
18.19 providing the services must meet the requirements of paragraph (b), and must be
18.20 located within an ambulatory care setting ~~approved by the commissioner~~ that meets the
18.21 requirements of paragraph (b), clause (3). The patient must also be located within an
18.22 ambulatory care setting ~~approved by the commissioner~~ that meets the requirements of
18.23 paragraph (b), clause (3). Services provided under this paragraph may not be transmitted
18.24 into the patient's residence.

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18.27 ~~chronic conditions and a high number of medications who are at high risk of preventable~~
18.28 ~~hospitalizations, emergency room use, medication complications, and suboptimal~~
18.29 ~~treatment outcomes due to medication-related problems. For purposes of the pilot~~
18.30 ~~project, medication therapy management services may be provided in a patient's home~~
18.31 ~~or community setting, in addition to other authorized settings. The commissioner may~~
18.32 ~~waive existing payment policies and establish special payment rates for the pilot project.~~
18.33 ~~The pilot project must be designed to produce a net savings to the state compared to the~~
18.34 ~~estimated costs that would otherwise be incurred for similar patients without the program.~~
18.35 ~~The pilot project must begin by January 1, 2010, and end June 30, 2012.~~

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351.12 (e) Medication therapy management services may be delivered into a patient's
351.13 residence via secure interactive video if the medication therapy management services
351.14 are performed electronically during a covered home care visit by an enrolled provider.
351.15 Reimbursement shall be at the same rates and under the same conditions that would
351.16 otherwise apply to the services provided. To qualify for reimbursement under this
351.17 paragraph, the pharmacist providing the services must meet the requirements of paragraph
351.18 (b) and must be located within an ambulatory care setting that meets the requirements of
351.19 paragraph (b), clause (3).

351.20 Sec. 22. Minnesota Statutes 2014, section 256B.0625, subdivision 14, is amended to
351.21 read:

351.22 Subd. 14. **Diagnostic, screening, and preventive services.** (a) Medical assistance
351.23 covers diagnostic, screening, and preventive services.

351.24 (b) "Preventive services" include services related to pregnancy, including:

351.25 (1) services for those conditions which may complicate a pregnancy and which may
351.26 be available to a pregnant woman determined to be at risk of poor pregnancy outcome;

351.27 (2) prenatal HIV risk assessment, education, counseling, and testing; and

351.28 (3) alcohol abuse assessment, education, and counseling on the effects of alcohol
351.29 usage while pregnant. Preventive services available to a woman at risk of poor pregnancy
351.30 outcome may differ in an amount, duration, or scope from those available to other
351.31 individuals eligible for medical assistance.

351.32 (c) "Screening services" include, but are not limited to~~,~~:

351.33 (1) blood lead tests~~.~~; and

351.34 (2) oral health screenings, using the risk factors established by the American
351.35 Academies of Pediatrics and Pediatric Dentistry, conducted by a licensed dental provider
352.1 in collaborative practice under section 150A.10, subdivision 1a, 150A.105, or 150A.106,
352.2 to determine an enrollee's need to be seen by a dentist for diagnosis and assessment
352.3 to identify possible signs of oral or systemic disease, malformation, or injury and the
352.4 potential need for referral for diagnosis and treatment. For purposes of this paragraph, oral
352.5 health screenings are limited to once per year, and the provider performing the screening
352.6 must have an agreement in effect that refers those needing necessary follow-up care to
352.7 a licensed dentist where the necessary care is provided.

352.8 (d) The commissioner shall encourage, at the time of the child and teen checkup or
352.9 at an episodic care visit, the primary care health care provider to perform primary caries
352.10 preventive services. Primary caries preventive services include, at a minimum:

352.11 (1) a general visual examination of the child's mouth without using probes or other
352.12 dental equipment or taking radiographs;

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19.1 (e) Medication therapy management services may be delivered into a patient's
19.2 residence via secure interactive video if the medication therapy management services
19.3 are performed electronically during a covered home care visit by an enrolled provider.
19.4 Reimbursement shall be at the same rates and under the same conditions that would
19.5 otherwise apply to the services provided. To qualify for reimbursement under this
19.6 paragraph, the pharmacist providing the services must meet the requirements of paragraph
19.7 (b) and must be located within an ambulatory care setting that meets the requirements of
19.8 paragraph (b), clause (3).

352.13 (2) a risk assessment using the factors established by the American Academies
352.14 of Pediatrics and Pediatric Dentistry; and

352.15 (3) the application of a fluoride varnish beginning at age one to those children
352.16 assessed by the provider as being high risk in accordance with best practices as defined by
352.17 the Department of Human Services. The provider must obtain parental or legal guardian
352.18 consent before a fluoride varnish is applied to a minor child's teeth.

352.19 At each checkup, if primary caries preventive services are provided, the provider must
352.20 provide to the child's parent or legal guardian: information on caries etiology and
352.21 prevention; and information on the importance of finding a dental home for their child
352.22 by the age of one. The provider must also advise the parent or legal guardian to contact
352.23 the child's managed care plan or the Department of Human Services in order to secure a
352.24 dental appointment with a dentist. The provider must indicate in the child's medical record
352.25 that the parent or legal guardian was provided with this information and document any
352.26 primary caries prevention services provided to the child.

352.27 Sec. 23. Minnesota Statutes 2014, section 256B.0625, subdivision 17, is amended to
352.28 read:

352.29 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation
352.30 service" means motor vehicle transportation provided by a public or private person
352.31 that serves Minnesota health care program beneficiaries who do not require emergency
352.32 ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered
352.33 medical services. ~~Nonemergency medical transportation service includes, but is not~~
352.34 ~~limited to, special transportation service, defined in section 174.29, subdivision 1.~~

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

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

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

353.9 (3) taxicabs ~~and~~;

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

353.11 ~~(4)~~ (5) not-for-hire vehicles, including volunteer drivers.

19.9 Sec. 12. Minnesota Statutes 2014, section 256B.0625, subdivision 17, is amended to
19.10 read:

19.11 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation
19.12 service" means motor vehicle transportation provided by a public or private person
19.13 that serves Minnesota health care program beneficiaries who do not require emergency
19.14 ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered
19.15 medical services. Nonemergency medical transportation service includes, but is not
19.16 limited to, special transportation service, defined in section 174.29, subdivision 1.

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

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

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

19.25 (3) taxicabs and public transit, as defined in section 174.22, subdivision 7; or

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

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353.12 (c) Medical assistance covers nonemergency medical transportation provided by
353.13 nonemergency medical transportation providers enrolled in the Minnesota health care
353.14 programs. All nonemergency medical transportation providers must comply with the
353.15 operating standards for special transportation service as defined in sections 174.29 to
353.16 174.30 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota
353.17 Department of Transportation. All nonemergency medical transportation providers shall
353.18 bill for nonemergency medical transportation services in accordance with Minnesota
353.19 health care programs criteria. Publicly operated transit systems, volunteers, and
353.20 not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

353.21 (d) The administrative agency of nonemergency medical transportation must:

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

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

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

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

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

354.1 (f) The commissioner may use an order by the recipient's attending physician or a
354.2 medical or mental health professional to certify that the recipient requires nonemergency
354.3 medical transportation services. Nonemergency medical transportation providers shall
354.4 perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted
354.5 service includes passenger pickup at and return to the individual's residence or place of
354.6 business, assistance with admittance of the individual to the medical facility, and assistance
354.7 in passenger securement or in securing of wheelchairs or stretchers in the vehicle.
354.8 ~~Nonemergency medical transportation providers must have trip logs, which include pickup~~
354.9 ~~and drop-off times, signed by the medical provider or client attesting mileage traveled to~~
354.10 ~~obtain covered medical services, whichever is deemed most appropriate. Nonemergency~~
354.11 ~~medical transportation providers may not bill for separate base rates for the continuation~~
354.12 ~~of a trip beyond the original destination. Nonemergency medical transportation providers~~
354.13 ~~must take clients to the health care provider, using the most direct route, and must not~~
354.14 ~~exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty~~

House Language UES1458-1

19.27 (c) Medical assistance covers nonemergency medical transportation provided by
19.28 nonemergency medical transportation providers enrolled in the Minnesota health care
19.29 programs. All nonemergency medical transportation providers must comply with the
19.30 operating standards for special transportation service as defined in sections 174.29 to
19.31 174.30 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota
19.32 Department of Transportation. All nonemergency medical transportation providers shall
19.33 bill for nonemergency medical transportation services in accordance with Minnesota
19.34 health care programs criteria. Publicly operated transit systems, volunteers, and
19.35 not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

20.1 (d) The administrative agency of nonemergency medical transportation must:

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

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

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

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

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

20.16 (f) The commissioner may use an order by the recipient's attending physician or a
20.17 medical or mental health professional to certify that the recipient requires nonemergency
20.18 medical transportation services. Nonemergency medical transportation providers shall
20.19 perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted
20.20 service includes passenger pickup at and return to the individual's residence or place of
20.21 business, assistance with admittance of the individual to the medical facility, and assistance
20.22 in passenger securement or in securing of wheelchairs or stretchers in the vehicle.
20.23 Nonemergency medical transportation providers must have trip logs, which include pickup
20.24 and drop-off times, signed by the medical provider or client attesting mileage traveled to
20.25 obtain covered medical services, whichever is deemed most appropriate. Nonemergency
20.26 medical transportation providers may not bill for separate base rates for the continuation
20.27 of a trip beyond the original destination. Nonemergency medical transportation providers
20.28 must take clients to the health care provider, using the most direct route, and must not
20.29 exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty

354.15 ~~care provider, unless the client receives authorization from the local agency. The minimum~~
354.16 ~~medical assistance reimbursement rates for special transportation services are:~~

354.17 ~~(1)(i) $17 for the base rate and $1.35 per mile for special transportation services to~~
354.18 ~~eligible persons who need a wheelchair-accessible van;~~

354.19 ~~(ii) $11.50 for the base rate and $1.30 per mile for special transportation services to~~
354.20 ~~eligible persons who do not need a wheelchair-accessible van; and~~

354.21 ~~(iii) $60 for the base rate and $2.40 per mile, and an attendant rate of $9 per trip,~~
354.22 ~~for special transportation services to eligible persons who need a stretcher-accessible~~
354.23 ~~vehicle; and~~

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

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

354.35 ~~(g) The covered modes of nonemergency medical transportation include~~
354.36 ~~transportation provided directly by clients or family members of clients with their own~~
355.1 ~~transportation, volunteers using their own vehicles, taxicabs, and public transit, or~~
355.2 ~~provided to a client who needs a stretcher-accessible vehicle, a lift/ramp equipped vehicle,~~
355.3 ~~or a vehicle that is not stretcher-accessible or lift/ramp equipped designed to transport ten~~
355.4 ~~or fewer persons. Upon implementation of a new rate structure, a new covered mode of~~
355.5 ~~nonemergency medical transportation shall include transportation provided to a client who~~
355.6 ~~needs a protected vehicle that is not an ambulance or police car and has safety locks, a~~
355.7 ~~video recorder, and a transparent thermoplastic partition between the passenger and the~~
355.8 ~~vehicle driver.~~

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

355.14 (h) The ~~new~~ covered modes of transportation, which may not be implemented
355.15 without a new rate structure, are:

20.30 care provider, unless the client receives authorization from the local agency. The minimum
20.31 medical assistance reimbursement rates for special transportation services are:

20.32 (1)(i) $17 for the base rate and $1.35 per mile for special transportation services to
20.33 eligible persons who need a wheelchair-accessible van;

20.34 (ii) $11.50 for the base rate and $1.30 per mile for special transportation services to
20.35 eligible persons who do not need a wheelchair-accessible van; and

21.1 (iii) $60 for the base rate and $2.40 per mile, and an attendant rate of $9 per trip,
21.2 for special transportation services to eligible persons who need a stretcher-accessible
21.3 vehicle; and

21.4 (2) clients requesting client mileage reimbursement must sign the trip log attesting
21.5 mileage traveled to obtain covered medical services.

21.6 (g) The covered modes of nonemergency medical transportation include
21.7 transportation provided directly by clients or family members of clients with their own
21.8 transportation, volunteers using their own vehicles, taxicabs, and public transit, or
21.9 provided to a client who needs a stretcher-accessible vehicle, a lift/ramp equipped vehicle,
21.10 or a vehicle that is not stretcher-accessible or lift/ramp equipped designed to transport ten
21.11 or fewer persons. Upon implementation of a new rate structure, a new covered mode of
21.12 nonemergency medical transportation shall include transportation provided to a client who
21.13 needs a protected vehicle that is not an ambulance or police car and has safety locks, a
21.14 video recorder, and a transparent thermoplastic partition between the passenger and the
21.15 vehicle driver.

21.16 (h) The administrative agency shall use the level of service process established by the
21.17 commissioner in consultation with the Nonemergency Medical Transportation Advisory
21.18 Committee to determine the client's most appropriate mode of transportation. If public
21.19 transit or a certified transportation provider is not available to provide the appropriate
21.20 service mode for the client, the client may receive a onetime service upgrade. The new
21.21 modes of transportation, which may not be implemented without a new rate structure, are:

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

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

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

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

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

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

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

356.4 (i) In accordance with subdivision 18e, by July 1, 2016, The local agency shall be
356.5 the single administrative agency and shall administer and reimburse for modes defined in
356.6 paragraph (h) according to a new rate structure, once this is adopted paragraphs (l) and
356.7 (m) when the commissioner has developed, made available, and funded the Web-based
356.8 single administrative structure, assessment tool, and level of need assessment under
356.9 subdivision 18e. The local agency's financial obligation is limited to funds provided by
356.10 the state or federal government.

356.11 (j) The commissioner shall:

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

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

356.16 (3) investigate all complaints and appeals.

House Language UES1458-1

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

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

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

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

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

22.1 (6) protected transport, which includes transport to a client who has received a
22.2 prescreening that has deemed other forms of transportation inappropriate and who requires
22.3 a provider certified as a protected transport provider; and

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

22.7 (i) In accordance with subdivision 18e, by July 1, 2016, The local agency shall be
22.8 the single administrative agency and shall administer and reimburse for modes defined in
22.9 paragraph (h) according to a new rate structure, once this is adopted when the commissioner
22.10 has developed, made available, and funded the Web-based single administrative structure,
22.11 assessment tool, and level of need assessment under subdivision 18e. The local agency's
22.12 financial obligation is limited to funds provided by the state or the federal government.

22.13 (j) The commissioner shall:

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

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

22.18 (3) investigate all complaints and appeals.

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356.17 (k) The administrative agency shall pay for the services provided in this subdivision
356.18 and seek reimbursement from the commissioner, if appropriate. As vendors of medical
356.19 care, local agencies are subject to the provisions in section 256B.041, the sanctions and
356.20 monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160
356.21 to 9505.2245.

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

356.27 (1) $0.22 per mile for client reimbursement;

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

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

356.33 (4) $13 for the base rate and $1.30 per mile for assisted transport;

356.34 (5) $18 for the base rate and $1.55 per mile for lift-equipped/ramp transport;

356.35 (6) $75 for the base rate and $2.40 per mile for protected transport; and

357.1 (7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip
357.2 for an additional attendant if deemed medically necessary.

357.3 ~~The base rates for special transportation services in areas defined under RUCA~~
357.4 ~~to be super rural shall be equal to the reimbursement rate established in paragraph (f),~~
357.5 ~~clause (1), plus 11.3 percent, and for special~~ (m) The base rate for nonemergency medical
357.6 transportation services in areas defined under RUCA to be super rural is equal to 111.3
357.7 percent of the respective base rate in paragraph (l), clauses (1) to (7). The mileage rate
357.8 for nonemergency medical transportation services in areas defined under RUCA to be
357.9 rural or super rural areas is:

357.10 (1) for a trip equal to 17 miles or less, ~~mileage reimbursement shall be~~ equal to 125
357.11 percent of the respective mileage rate in paragraph ~~(f)~~ (l), ~~clause~~ clauses (1) to (7); and

357.12 (2) for a trip between 18 and 50 miles, ~~mileage reimbursement shall be~~ equal to
357.13 112.5 percent of the respective mileage rate in paragraph ~~(f)~~ (l), ~~clause~~ clauses (1) to (7).

357.14 ~~(m)~~ (n) For purposes of reimbursement rates for ~~special~~ nonemergency medical
357.15 transportation services under ~~paragraph (c)~~ paragraphs (l) and (m), the zip code of the
357.16 recipient's place of residence shall determine whether the urban, rural, or super rural
357.17 reimbursement rate applies.

House Language UES1458-1

22.19 (k) The administrative agency shall pay for the services provided in this subdivision
22.20 and seek reimbursement from the commissioner, if appropriate. As vendors of medical
22.21 care, local agencies are subject to the provisions in section 256B.041, the sanctions and
22.22 monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160
22.23 to 9505.2245.

22.24 (l) The base rates for special transportation services in areas defined under RUCA to
22.25 be super rural shall be equal to the reimbursement rate established in paragraph (f), clause
22.26 (1), plus 11.3 percent, and for special transportation services in areas defined under RUCA
22.27 to be rural or super rural areas:

22.28 (1) for a trip equal to 17 miles or less, mileage reimbursement shall be equal to 125
22.29 percent of the respective mileage rate in paragraph (f), clause (1); and

22.30 (2) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to
22.31 112.5 percent of the respective mileage rate in paragraph (f), clause (1).

22.32 (m) For purposes of reimbursement rates for special transportation services under
22.33 paragraph (c), the zip code of the recipient's place of residence shall determine whether
22.34 the urban, rural, or super rural reimbursement rate applies.

Senate Language S1458-2

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

357.21 ~~(o) Effective for services provided on or after September 1, 2011, nonemergency~~
357.22 ~~transportation rates, including special transportation, taxi, and other commercial carriers,~~
357.23 ~~are reduced 4.5 percent. Payments made to managed care plans and county-based~~
357.24 ~~purchasing plans must be reduced for services provided on or after January 1, 2012,~~
357.25 ~~to reflect this reduction.~~

357.26 **EFFECTIVE DATE.** This section is effective July 1, 2016.

357.27 Sec. 24. Minnesota Statutes 2014, section 256B.0625, subdivision 17a, is amended to
357.28 read:

357.29 Subd. 17a. **Payment for ambulance services.** ~~(a)~~ Medical assistance covers
357.30 ambulance services. Providers shall bill ambulance services according to Medicare
357.31 criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective
357.32 for services rendered on or after July 1, 2001, medical assistance payments for ambulance
357.33 services shall be paid at the Medicare reimbursement rate or at the medical assistance
357.34 payment rate in effect on July 1, 2000, whichever is greater.

358.1 ~~(b) Effective for services provided on or after September 1, 2011, ambulance~~
358.2 ~~services payment rates are reduced 4.5 percent. Payments made to managed care plans~~
358.3 ~~and county-based purchasing plans must be reduced for services provided on or after~~
358.4 ~~January 1, 2012, to reflect this reduction.~~

358.5 **EFFECTIVE DATE.** This section is effective July 1, 2016.

358.6 Sec. 25. Minnesota Statutes 2014, section 256B.0625, subdivision 18a, is amended to
358.7 read:

358.8 Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for
358.9 meals for persons traveling to receive medical care may not exceed $5.50 for breakfast,
358.10 $6.50 for lunch, or $8 for dinner.

358.11 (b) Medical assistance reimbursement for lodging for persons traveling to receive
358.12 medical care may not exceed $50 per day unless prior authorized by the local agency.

358.13 (c) ~~Medical assistance direct mileage reimbursement to the eligible person or the~~
358.14 ~~eligible person's driver may not exceed 20 cents per mile.~~

House Language UES1458-1

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

23.4 (o) Effective for services provided on or after September 1, 2011, nonemergency
23.5 transportation rates, including special transportation, taxi, and other commercial carriers,
23.6 are reduced 4.5 percent. Payments made to managed care plans and county-based
23.7 purchasing plans must be reduced for services provided on or after January 1, 2012,
23.8 to reflect this reduction.

358.15 ~~(d)~~ Regardless of the number of employees that an enrolled health care provider
358.16 may have, medical assistance covers sign and oral language interpreter services when
358.17 provided by an enrolled health care provider during the course of providing a direct,
358.18 person-to-person covered health care service to an enrolled recipient with limited English
358.19 proficiency or who has a hearing loss and uses interpreting services. Coverage for
358.20 face-to-face oral language interpreter services shall be provided only if the oral language
358.21 interpreter used by the enrolled health care provider is listed in the registry or roster
358.22 established under section 144.058.

358.23 **EFFECTIVE DATE.** This section is effective July 1, 2016.

358.24 Sec. 26. Minnesota Statutes 2014, section 256B.0625, subdivision 18e, is amended to
358.25 read:

358.26 Subd. 18e. **Single administrative structure and delivery system.** The
358.27 commissioner, in coordination with the commissioner of transportation, shall implement
358.28 a single administrative structure and delivery system for nonemergency medical
358.29 transportation, beginning the latter of the date the single administrative assessment tool
358.30 required in this subdivision is available for use, as determined by the commissioner or by
358.31 July 1, 2016.

358.32 In coordination with the Department of Transportation, the commissioner shall
358.33 develop and authorize a Web-based single administrative structure and assessment
359.1 tool, which must operate 24 hours a day, seven days a week, to facilitate the enrollee
359.2 assessment process for nonemergency medical transportation services. The Web-based
359.3 tool shall facilitate the transportation eligibility determination process initiated by clients
359.4 and client advocates; shall include an accessible automated intake and assessment
359.5 process and real-time identification of level of service eligibility; and shall authorize an
359.6 appropriate and auditable mode of transportation authorization. The tool shall provide a
359.7 single framework for reconciling trip information with claiming and collecting complaints
359.8 regarding inappropriate level of need determinations, inappropriate transportation modes
359.9 utilized, and interference with accessing nonemergency medical transportation. The
359.10 Web-based single administrative structure shall operate on a trial basis for one year from
359.11 implementation and, if approved by the commissioner, shall be permanent thereafter.
359.12 The commissioner shall seek input from the Nonemergency Medical Transportation
359.13 Advisory Committee to ensure the software is effective and user-friendly and make
359.14 recommendations regarding funding of the single administrative system.

359.15 **EFFECTIVE DATE.** This section is effective July 1, 2015.

Senate Language S1458-2

359.16 Sec. 27. Minnesota Statutes 2014, section 256B.0625, subdivision 31, is amended to
359.17 read:

359.18 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical
359.19 supplies and equipment. Separate payment outside of the facility's payment rate shall
359.20 be made for wheelchairs and wheelchair accessories for recipients who are residents
359.21 of intermediate care facilities for the developmentally disabled. Reimbursement for
359.22 wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same
359.23 conditions and limitations as coverage for recipients who do not reside in institutions. A
359.24 wheelchair purchased outside of the facility's payment rate is the property of the recipient.
359.25 ~~The commissioner may set reimbursement rates for specified categories of medical~~
359.26 ~~supplies at levels below the Medicare payment rate.~~

359.27 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies
359.28 must enroll as a Medicare provider.

359.29 (c) When necessary to ensure access to durable medical equipment, prosthetics,
359.30 orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare
359.31 enrollment requirement if:

359.32 (1) the vendor supplies only one type of durable medical equipment, prosthetic,
359.33 orthotic, or medical supply;

359.34 (2) the vendor serves ten or fewer medical assistance recipients per year;

360.1 (3) the commissioner finds that other vendors are not available to provide same or
360.2 similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

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23.9 Sec. 13. Minnesota Statutes 2014, section 256B.0625, subdivision 28a, is amended to
23.10 read:

23.11 Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers
23.12 services performed by a licensed physician assistant if the service is otherwise covered
23.13 under this chapter as a physician service and if the service is within the scope of practice
23.14 of a licensed physician assistant as defined in section 147A.09.

23.15 (b) Licensed physician assistants, who are supervised by a physician certified by
23.16 the American Board of Psychiatry and Neurology or eligible for board certification in
23.17 psychiatry, may bill for medication management and evaluation and management services
23.18 provided to medical assistance enrollees in inpatient hospital settings, and in outpatient
23.19 settings after the licensed physician assistant completes 2,000 hours of clinical experience
23.20 in the evaluation and treatment of mental health, consistent with their authorized scope of
23.21 practice, as defined in section 147A.09, with the exception of performing psychotherapy
23.22 or diagnostic assessments or providing clinical supervision.

23.23 Sec. 14. Minnesota Statutes 2014, section 256B.0625, subdivision 31, is amended to
23.24 read:

23.25 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical
23.26 supplies and equipment. Separate payment outside of the facility's payment rate shall
23.27 be made for wheelchairs and wheelchair accessories for recipients who are residents
23.28 of intermediate care facilities for the developmentally disabled. Reimbursement for
23.29 wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same
23.30 conditions and limitations as coverage for recipients who do not reside in institutions. A
23.31 wheelchair purchased outside of the facility's payment rate is the property of the recipient.
23.32 ~~The commissioner may set reimbursement rates for specified categories of medical~~
23.33 ~~supplies at levels below the Medicare payment rate.~~

24.1 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies
24.2 must enroll as a Medicare provider.

24.3 (c) When necessary to ensure access to durable medical equipment, prosthetics,
24.4 orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare
24.5 enrollment requirement if:

24.6 (1) the vendor supplies only one type of durable medical equipment, prosthetic,
24.7 orthotic, or medical supply;

24.8 (2) the vendor serves ten or fewer medical assistance recipients per year;

24.9 (3) the commissioner finds that other vendors are not available to provide same or
24.10 similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

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360.3 (4) the vendor complies with all screening requirements in this chapter and Code of
360.4 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from
360.5 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare
360.6 and Medicaid Services approved national accreditation organization as complying with
360.7 the Medicare program's supplier and quality standards and the vendor serves primarily
360.8 pediatric patients.

360.9 (d) Durable medical equipment means a device or equipment that:

360.10 (1) can withstand repeated use;

360.11 (2) is generally not useful in the absence of an illness, injury, or disability; and

360.12 (3) is provided to correct or accommodate a physiological disorder or physical
360.13 condition or is generally used primarily for a medical purpose.

360.14 (e) Electronic tablets may be considered durable medical equipment if the electronic
360.15 tablet will be used as an augmentative and alternative communication system as defined
360.16 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device
360.17 must be locked in order to prevent use not related to communication.

360.18 Sec. 28. Minnesota Statutes 2014, section 256B.0625, subdivision 57, is amended to
360.19 read:

360.20 Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for
360.21 services provided on or after January 1, 2012, medical assistance payment for an enrollee's
360.22 cost-sharing associated with Medicare Part B is limited to an amount up to the medical
360.23 assistance total allowed, when the medical assistance rate exceeds the amount paid by
360.24 Medicare.

360.25 (b) Excluded from this limitation are payments for mental health services and
360.26 payments for dialysis services provided to end-stage renal disease patients. The exclusion
360.27 for mental health services does not apply to payments for physician services provided by
360.28 psychiatrists and advanced practice nurses with a specialty in mental health.

360.29 (c) Excluded from this limitation are payments to federally qualified health centers
360.30 and rural health clinics.

360.31 **EFFECTIVE DATE.** This section is effective January 1, 2016.

360.32 Sec. 29. Minnesota Statutes 2014, section 256B.0625, subdivision 58, is amended to
360.33 read:

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24.11 (4) the vendor complies with all screening requirements in this chapter and Code of
24.12 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from
24.13 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare
24.14 and Medicaid Services approved national accreditation organization as complying with
24.15 the Medicare program's supplier and quality standards and the vendor serves primarily
24.16 pediatric patients.

24.17 (d) Durable medical equipment means a device or equipment that:

24.18 (1) can withstand repeated use;

24.19 (2) is generally not useful in the absence of an illness, injury, or disability; and

24.20 (3) is provided to correct or accommodate a physiological disorder or physical
24.21 condition or is generally used primarily for a medical purpose.

24.22 (e) Electronic tablets may be considered durable medical equipment if the electronic
24.23 tablet will be used as an augmentative and alternative communication system as defined
24.24 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device
24.25 must be locked in order to prevent use not related to communication.

24.26 Sec. 15. Minnesota Statutes 2014, section 256B.0625, subdivision 58, is amended to
24.27 read:

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

361.7 Sec. 30. Minnesota Statutes 2014, section 256B.0631, is amended to read:
361.8 **256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.**

361.9 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
361.10 assistance benefit plan shall include the following cost-sharing for all recipients, effective
361.11 for services provided on or after September 1, 2011:

361.12 (1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes
361.13 of this subdivision, a visit means an episode of service which is required because of
361.14 a recipient's symptoms, diagnosis, or established illness, and which is delivered in an
361.15 ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse
361.16 midwife, advanced practice nurse, audiologist, optician, or optometrist;

361.17 (2) $3.50 for nonemergency visits to a hospital-based emergency room, except that
361.18 this co-payment shall be increased to $20 upon federal approval;

361.19 (3) $3 per brand-name drug prescription and $1 per generic drug prescription,
361.20 subject to a $12 per month maximum for prescription drug co-payments. No co-payments
361.21 shall apply to antipsychotic drugs when used for the treatment of mental illness;

361.22 (4) ~~effective January 1, 2012,~~ a family deductible equal to ~~the maximum amount~~
361.23 ~~allowed under Code of Federal Regulations, title 42, part 447.54~~ $2.75 per month per
361.24 family and adjusted annually by the percentage increase in the medical care component
361.25 of the CPI-U for the period of September to September of the preceding calendar year,
361.26 rounded to the next higher five-cent increment; and

361.27 (5) ~~for individuals identified by the commissioner with income at or below 100~~
361.28 ~~percent of the federal poverty guidelines,~~ total monthly cost-sharing must not exceed five
361.29 percent of family income. For purposes of this paragraph, family income is the total
361.30 earned and unearned income of the individual and the individual's spouse, if the spouse is
361.31 enrolled in medical assistance and also subject to the five percent limit on cost-sharing.
361.32 This paragraph does not apply to premiums charged to individuals described under section
361.33 256B.057, subdivision 9.

361.34 (b) Recipients of medical assistance are responsible for all co-payments and
361.35 deductibles in this subdivision.

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

25.1 Sec. 16. Minnesota Statutes 2014, section 256B.0631, is amended to read:
25.2 **256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.**

25.3 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
25.4 assistance benefit plan shall include the following cost-sharing for all recipients, effective
25.5 for services provided on or after September 1, 2011:

25.6 (1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes
25.7 of this subdivision, a visit means an episode of service which is required because of
25.8 a recipient's symptoms, diagnosis, or established illness, and which is delivered in an
25.9 ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse
25.10 midwife, advanced practice nurse, audiologist, optician, or optometrist;

25.11 (2) $3.50 for nonemergency visits to a hospital-based emergency room, except that
25.12 this co-payment shall be increased to $20 upon federal approval;

25.13 (3) $3 per brand-name drug prescription and $1 per generic drug prescription,
25.14 subject to a $12 per month maximum for prescription drug co-payments. No co-payments
25.15 shall apply to antipsychotic drugs when used for the treatment of mental illness;

25.16 (4) ~~effective January 1, 2012,~~ a family deductible equal to ~~the maximum amount~~
25.17 ~~allowed under Code of Federal Regulations, title 42, part 447.54~~ $2.75 per month per
25.18 family and adjusted annually by the percentage increase in the medical care component
25.19 of the CPI-U for the period of September to September of the preceding calendar year,
25.20 rounded to the next higher five-cent increment; and

25.21 (5) ~~for individuals identified by the commissioner with income at or below 100~~
25.22 ~~percent of the federal poverty guidelines,~~ total monthly cost-sharing must not exceed five
25.23 percent of family income. For purposes of this paragraph, family income is the total
25.24 earned and unearned income of the individual and the individual's spouse, if the spouse is
25.25 enrolled in medical assistance and also subject to the five percent limit on cost-sharing.
25.26 This paragraph does not apply to premiums charged to individuals described under section
25.27 256B.057, subdivision 9.

25.28 (b) Recipients of medical assistance are responsible for all co-payments and
25.29 deductibles in this subdivision.

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362.1 (c) Notwithstanding paragraph (b), the commissioner, through the contracting
362.2 process under sections 256B.69 and 256B.692, may allow managed care plans and
362.3 county-based purchasing plans to waive the family deductible under paragraph (a),
362.4 clause (4). The value of the family deductible shall not be included in the capitation
362.5 payment to managed care plans and county-based purchasing plans. Managed care plans
362.6 and county-based purchasing plans shall certify annually to the commissioner the dollar
362.7 value of the family deductible.

362.8 (d) Notwithstanding paragraph (b), the commissioner may waive the collection of
362.9 the family deductible described under paragraph (a), clause (4), from individuals and
362.10 allow long-term care and waivered service providers to assume responsibility for payment.

362.11 (e) Notwithstanding paragraph (b), the commissioner, through the contracting
362.12 process under section 256B.0756 shall allow the pilot program in Hennepin County to
362.13 waive co-payments. The value of the co-payments shall not be included in the capitation
362.14 payment amount to the integrated health care delivery networks under the pilot program.

362.15 Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following
362.16 exceptions:

362.17 (1) children under the age of 21;

362.18 (2) pregnant women for services that relate to the pregnancy or any other medical
362.19 condition that may complicate the pregnancy;

362.20 (3) recipients expected to reside for at least 30 days in a hospital, nursing home, or
362.21 intermediate care facility for the developmentally disabled;

362.22 (4) recipients receiving hospice care;

362.23 (5) 100 percent federally funded services provided by an Indian health service;

362.24 (6) emergency services;

362.25 (7) family planning services;

362.26 (8) services that are paid by Medicare, resulting in the medical assistance program
362.27 paying for the coinsurance and deductible;

362.28 (9) co-payments that exceed one per day per provider for nonpreventive visits,
362.29 eyeglasses, and nonemergency visits to a hospital-based emergency room; ~~and~~

362.30 (10) services, fee-for-service payments subject to volume purchase through
362.31 competitive bidding~~.~~;

362.32 (11) American Indians who meet the requirements in Code of Federal Regulations,
362.33 title 42, section 447.51;

362.34 (12) persons needing treatment for breast or cervical cancer as described under
362.35 section 256B.057, subdivision 10; and

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25.30 (c) Notwithstanding paragraph (b), the commissioner, through the contracting
25.31 process under sections 256B.69 and 256B.692, may allow managed care plans and
25.32 county-based purchasing plans to waive the family deductible under paragraph (a),
25.33 clause (4). The value of the family deductible shall not be included in the capitation
25.34 payment to managed care plans and county-based purchasing plans. Managed care plans
25.35 and county-based purchasing plans shall certify annually to the commissioner the dollar
25.36 value of the family deductible.

26.1 (d) Notwithstanding paragraph (b), the commissioner may waive the collection of
26.2 the family deductible described under paragraph (a), clause (4), from individuals and
26.3 allow long-term care and waivered service providers to assume responsibility for payment.

26.4 (e) Notwithstanding paragraph (b), the commissioner, through the contracting
26.5 process under section 256B.0756 shall allow the pilot program in Hennepin County to
26.6 waive co-payments. The value of the co-payments shall not be included in the capitation
26.7 payment amount to the integrated health care delivery networks under the pilot program.

26.8 Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following
26.9 exceptions:

26.10 (1) children under the age of 21;

26.11 (2) pregnant women for services that relate to the pregnancy or any other medical
26.12 condition that may complicate the pregnancy;

26.13 (3) recipients expected to reside for at least 30 days in a hospital, nursing home, or
26.14 intermediate care facility for the developmentally disabled;

26.15 (4) recipients receiving hospice care;

26.16 (5) 100 percent federally funded services provided by an Indian health service;

26.17 (6) emergency services;

26.18 (7) family planning services;

26.19 (8) services that are paid by Medicare, resulting in the medical assistance program
26.20 paying for the coinsurance and deductible;

26.21 (9) co-payments that exceed one per day per provider for nonpreventive visits,
26.22 eyeglasses, and nonemergency visits to a hospital-based emergency room; ~~and~~

26.23 (10) services, fee-for-service payments subject to volume purchase through
26.24 competitive bidding~~.~~;

26.25 (11) American Indians who meet the requirements in Code of Federal Regulations,
26.26 title 42, section 447.51;

26.27 (12) persons needing treatment for breast or cervical cancer as described under
26.28 section 256B.057, subdivision 10; and

363.1 (13) services that currently have a rating of A or B from the United States Preventive
363.2 Services Task Force (USPSTF), immunizations recommended by the Advisory Committee
363.3 on Immunization Practices of the Centers for Disease Control and Prevention, and
363.4 preventive services and screenings provided to women as described in Code of Federal
363.5 Regulations, title 45, section 147.130.

363.6 Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall
363.7 be reduced by the amount of the co-payment or deductible, except that reimbursements
363.8 shall not be reduced:

363.9 (1) once a recipient has reached the $12 per month maximum for prescription drug
363.10 co-payments; or

363.11 (2) for a recipient ~~identified by the commissioner under 100 percent of the federal~~
363.12 ~~poverty guidelines~~ who has met their monthly five percent cost-sharing limit.

363.13 (b) The provider collects the co-payment or deductible from the recipient. Providers
363.14 may not deny services to recipients who are unable to pay the co-payment or deductible.

363.15 (c) Medical assistance reimbursement to fee-for-service providers and payments to
363.16 managed care plans shall not be increased as a result of the removal of co-payments or
363.17 deductibles effective on or after January 1, 2009.

363.18 **EFFECTIVE DATE.** The amendment to subdivision 1, paragraph (a), clause (4), is
363.19 effective retroactively from January 1, 2014.

363.20 Sec. 31. **[256B.0638] OPIOID PRESCRIBING IMPROVEMENT PROGRAM.**

363.21 Subdivision 1. **Program established.** The commissioner of human services, in
363.22 conjunction with the commissioner of health, shall coordinate and implement an opioid
363.23 prescribing improvement program to reduce opioid dependency and substance use by
363.24 Minnesotans due to the prescribing of opioid analgesics by health care providers.

363.25 Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this
363.26 subdivision have the meanings given them.

363.27 (b) "Commissioner" means the commissioner of human services.

363.28 (c) "Commissioners" means the commissioner of human services and the
363.29 commissioner of health.

363.30 (d) "DEA" means the United States Drug Enforcement Administration.

363.31 (e) "Minnesota health care program" means a public health care program
363.32 administered by the commissioner of human services under chapters 256B and 256L, and
363.33 the Minnesota restricted recipient program.

26.29 (13) services that currently have a rating of A or B from the United States Preventive
26.30 Services Task Force (USPSTF), immunizations recommended by the Advisory Committee
26.31 on Immunization Practices of the Centers for Disease Control and Prevention, and
26.32 preventive services and screenings provided to women as described in Code of Federal
26.33 Regulations, title 45, section 147.130.

26.34 Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall
26.35 be reduced by the amount of the co-payment or deductible, except that reimbursements
26.36 shall not be reduced:

27.1 (1) once a recipient has reached the $12 per month maximum for prescription drug
27.2 co-payments; or

27.3 (2) for a recipient ~~identified by the commissioner under 100 percent of the federal~~
27.4 ~~poverty guidelines~~ who has met their monthly five percent cost-sharing limit.

27.5 (b) The provider collects the co-payment or deductible from the recipient. Providers
27.6 may not deny services to recipients who are unable to pay the co-payment or deductible.

27.7 (c) Medical assistance reimbursement to fee-for-service providers and payments to
27.8 managed care plans shall not be increased as a result of the removal of co-payments or
27.9 deductibles effective on or after January 1, 2009.

27.10 **EFFECTIVE DATE.** The amendment to subdivision 1, paragraph (a), clause (4), is
27.11 effective retroactively from January 1, 2014.

364.1 (f) "Opioid disenrollment standards" means parameters of opioid prescribing
364.2 practices that fall outside community standard thresholds for prescribing to such a degree
364.3 that a provider must be disenrolled as a medical assistance provider.

364.4 (g) "Opioid prescriber" means a licensed health care provider who prescribes opioids
364.5 to medical assistance and MinnesotaCare enrollees under the fee-for-service system or
364.6 under a managed care or county-based purchasing plan.

364.7 (h) "Opioid quality improvement standard thresholds" means parameters of opioid
364.8 prescribing practices that fall outside community standards for prescribing to such a
364.9 degree that quality improvement is required.

364.10 (i) "Program" means the statewide opioid prescribing improvement program
364.11 established under this section.

364.12 (j) "Provider group" means a clinic, hospital, or primary or specialty practice group
364.13 that employs, contracts with, or is affiliated with an opioid prescriber. Provider group does
364.14 not include a professional association supported by dues-paying members.

364.15 (k) "Sentinel measures" means measures of opioid use that identify variations in
364.16 prescribing practices during the prescribing intervals.

364.17 Subd. 3. **Opioid prescribing work group.** (a) The commissioner of human
364.18 services, in consultation with the commissioner of health, shall appoint the following
364.19 voting members to an opioid prescribing work group:

364.20 (1) two consumer members who have been impacted by an opioid abuse disorder or
364.21 opioid dependence disorder, either personally or with family members;

364.22 (2) one member who is a licensed physician actively practicing in Minnesota and
364.23 registered as a practitioner with the DEA;

364.24 (3) one member who is a licensed pharmacist actively practicing in Minnesota and
364.25 registered as a practitioner with the DEA;

364.26 (4) one member who is a licensed nurse practitioner actively practicing in Minnesota
364.27 and registered as a practitioner with the DEA;

364.28 (5) one member who is a licensed dentist actively practicing in Minnesota and
364.29 registered as a practitioner with the DEA;

364.30 (6) two members who are nonphysician licensed health care professionals actively
364.31 engaged in the practice of their profession in Minnesota, and their practice includes
364.32 treating pain;

364.33 (7) one member who is a mental health professional who is licensed or registered
364.34 in a mental health profession, who is actively engaged in the practice of that profession
364.35 in Minnesota, and whose practice includes treating patients with chemical dependency
364.36 or substance abuse;

365.1 (8) one member who is a medical examiner for a Minnesota county;

365.2 (9) one member of the Health Services Policy Committee established under section
365.3 256B.0625, subdivisions 3c to 3e;

365.4 (10) one member who is a medical director of a health plan company doing business
365.5 in Minnesota;

365.6 (11) one member who is a pharmacy director of a health plan company doing
365.7 business in Minnesota; and

365.8 (12) one member representing Minnesota law enforcement.

365.9 (b) In addition, the work group shall include the following nonvoting members:

365.10 (1) the medical director for the medical assistance program;

365.11 (2) a member representing the Department of Human Services pharmacy unit; and

365.12 (3) the medical director for the Department of Labor and Industry.

365.13 (c) An honorarium of $200 per meeting and reimbursement for mileage and parking
365.14 shall be paid to each voting member in attendance.

365.15 Subd. 4. **Program components.** (a) The working group shall recommend to the
365.16 commissioners the components of the statewide opioid prescribing improvement program,
365.17 including, but not limited to, the following:

365.18 (1) developing criteria for opioid prescribing protocols, including:

365.19 (i) prescribing for the interval of up to four days immediately after an acute painful
365.20 event;

365.21 (ii) prescribing for the interval of up to 45 days after an acute painful event; and

365.22 (iii) prescribing for chronic pain, which for purposes of this program means pain
365.23 lasting longer than 45 days after an acute painful event;

365.24 (2) developing sentinel measures;

365.25 (3) developing educational resources for opioid prescribers about communicating
365.26 with patients about pain management and the use of opioids to treat pain;

365.27 (4) developing opioid quality improvement standard thresholds and opioid
365.28 disenrollment standards for opioid prescribers and provider groups. In developing opioid
365.29 disenrollment standards, the standards may be described in terms of the length of time in
365.30 which prescribing practices fall outside community standards and the nature and amount
365.31 of opioid prescribing that fall outside community standards; and

365.32 (5) addressing other program issues as determined by the commissioners.

365.33 (b) The opioid prescribing protocols shall not apply to opioids prescribed for patients
365.34 who are experiencing pain caused by a malignant condition or who are receiving hospice
365.35 care, or to opioids prescribed as medication-assisted therapy to treat opioid dependency.

366.1 (c) All opioid prescribers who prescribe opioids to Minnesota health care program
366.2 enrollees must participate in the program in accordance with subdivision 5. Any other
366.3 prescriber who prescribes opioids may comply with the components of this program
366.4 described in paragraph (a) on a voluntary basis.

366.5 Subd. 5. **Program implementation.** (a) The commissioner shall implement the
366.6 programs within the Minnesota health care program to improve the health of and quality
366.7 of care provided to Minnesota health care program enrollees. The commissioner shall
366.8 annually collect and report to opioid prescribers data showing the sentinel measures of
366.9 their opioid prescribing patterns compared to their anonymized peers.

366.10 (b) The commissioner shall notify an opioid prescriber and all provider groups
366.11 with which the opioid prescriber is employed or affiliated when the opioid prescriber's
366.12 prescribing pattern exceeds the opioid quality improvement standard thresholds. An
366.13 opioid prescriber and any provider group that receives a notice under this paragraph shall
366.14 submit to the commissioner a quality improvement plan for review and approval by the
366.15 commissioner with the goal of bringing the opioid prescriber's prescribing practices into
366.16 alignment with community standards. A quality improvement plan must include:

366.17 (1) components of the program described in subdivision 4, paragraph (a);

366.18 (2) internal practice-based measures to review the prescribing practice of the
366.19 opioid prescriber and, where appropriate, any other opioid prescribers employed by or
366.20 affiliated with any of the provider groups with which the opioid prescriber is employed or
366.21 affiliated; and

366.22 (3) appropriate use of the prescription monitoring program under section 152.126.

366.23 (c) If, after a year from the commissioner's notice under paragraph (b), the opioid
366.24 prescriber's prescribing practices do not improve so that they are consistent with
366.25 community standards, the commissioner shall take one or more of the following steps:

366.26 (1) monitor prescribing practices more frequently than annually;

366.27 (2) monitor more aspects of the opioid prescriber's prescribing practices than the
366.28 sentinel measures; or

366.29 (3) require the opioid prescriber to participate in additional quality improvement
366.30 efforts, including but not limited to mandatory use of the prescription monitoring program
366.31 established under section 152.126.

366.32 (d) The commissioner shall terminate from Minnesota health care programs all
366.33 opioid prescribers and provider groups whose prescribing practices fall within the
366.34 applicable opioid disenrollment standards.

366.35 Subd. 6. **Data practices.** (a) Reports and data identifying an opioid prescriber
366.36 are private data on individuals as defined under section 13.02, subdivision 12, until an
367.1 opioid prescriber is subject to termination as a medical assistance provider under this
367.2 section. Notwithstanding this data classification, the commissioner shall share with all of
367.3 the provider groups with which an opioid prescriber is employed or affiliated, a report
367.4 identifying an opioid prescriber who is subject to quality improvement activities under
367.5 subdivision 5, paragraph (b) or (c).

367.6 (b) Reports and data identifying a provider group are nonpublic data as defined
367.7 under section 13.02, subdivision 9, until the provider group is subject to termination as a
367.8 medical assistance provider under this section.

367.9 (c) Upon termination under this section, reports and data identifying an opioid
367.10 prescriber or provider group are public, except that any identifying information of
367.11 Minnesota health care program enrollees must be redacted by the commissioner.

367.12 Subd. 7. **Annual report to legislature.** By September 15, 2016, and annually
367.13 thereafter, the commissioner of human services shall report to the legislature on the
367.14 implementation of the opioid prescribing improvement program in the Minnesota health
367.15 care programs. The report must include data on the utilization of opioids within the
367.16 Minnesota health care programs.

27.12 Sec. 17. Minnesota Statutes 2014, section 256B.0644, is amended to read:
27.13 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**
27.14 **PROGRAMS.**

27.15 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a
27.16 health maintenance organization, as defined in chapter 62D, must participate as a provider
27.17 or contractor in the medical assistance program and MinnesotaCare as a condition of
27.18 participating as a provider in health insurance plans and programs or contractor for state
27.19 employees established under section 43A.18, the public employees insurance program
27.20 under section 43A.316, for health insurance plans offered to local statutory or home
27.21 rule charter city, county, and school district employees, the workers' compensation
27.22 system under section 176.135, and insurance plans provided through the Minnesota
27.23 Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations
27.24 on insurance plans offered to local government employees shall not be applicable in
27.25 geographic areas where provider participation is limited by managed care contracts
27.26 with the Department of Human Services. This section does not apply to dental service
27.27 providers providing dental services outside the seven-county metropolitan area.

27.28 (b) For providers other than health maintenance organizations, participation in the
27.29 medical assistance program means that:

27.30 (1) the provider accepts new medical assistance and MinnesotaCare patients;

27.31 (2) for providers other than dental service providers, at least 20 percent of the
27.32 provider's patients are covered by medical assistance and MinnesotaCare as their primary
27.33 source of coverage; or

28.1 (3) for dental service providers providing dental services in the seven-county
28.2 metropolitan area, at least ten percent of the provider's patients are covered by medical
28.3 assistance and MinnesotaCare as their primary source of coverage, or the provider accepts
28.4 new medical assistance and MinnesotaCare patients who are children with special health
28.5 care needs. For purposes of this section, "children with special health care needs" means
28.6 children up to age 18 who: (i) require health and related services beyond that required
28.7 by children generally; and (ii) have or are at risk for a chronic physical, developmental,
28.8 behavioral, or emotional condition, including: bleeding and coagulation disorders;
28.9 immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities;
28.10 epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness;
28.11 Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other
28.12 conditions designated by the commissioner after consultation with representatives of
28.13 pediatric dental providers and consumers.

28.14 (c) Patients seen on a volunteer basis by the provider at a location other than
28.15 the provider's usual place of practice may be considered in meeting the participation
28.16 requirement in this section. The commissioner shall establish participation requirements
28.17 for health maintenance organizations. The commissioner shall provide lists of participating
28.18 medical assistance providers on a quarterly basis to the commissioner of management and
28.19 budget, the commissioner of labor and industry, and the commissioner of commerce. Each
28.20 of the commissioners shall develop and implement procedures to exclude as participating
28.21 providers in the program or programs under their jurisdiction those providers who do
28.22 not participate in the medical assistance program. The commissioner of management
28.23 and budget shall implement this section through contracts with participating health and
28.24 dental carriers.

28.25 (d) A volunteer dentist who has signed a volunteer agreement under section
28.26 256B.0625, subdivision 9a, shall not be considered to be participating in medical
28.27 assistance or MinnesotaCare for the purpose of this section.

28.28 **EFFECTIVE DATE.** This section is effective upon receipt of any necessary federal
28.29 waiver or approval. The commissioner of human services shall notify the revisor of
28.30 statutes if a federal waiver or approval is sought and, if sought, when a federal waiver
28.31 or approval is obtained.

367.17 Sec. 32. Minnesota Statutes 2014, section 256B.0757, is amended to read:
367.18 **256B.0757 COORDINATED CARE THROUGH A HEALTH HOME.**

367.19 Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide
367.20 medical assistance coverage of health home services for eligible individuals with chronic
367.21 conditions who select a designated provider~~, a team of health care professionals, or a~~
367.22 ~~health team~~ as the individual's health home.

367.23 (b) The commissioner shall implement this section in compliance with the
367.24 requirements of the state option to provide health homes for enrollees with chronic
367.25 conditions, as provided under the Patient Protection and Affordable Care Act, Public
367.26 Law 111-148, sections 2703 and 3502. Terms used in this section have the meaning
367.27 provided in that act.

367.28 (c) The commissioner shall establish health homes to serve populations with serious
367.29 mental illness who meet the eligibility requirements described under subdivision 2, clause
367.30 (4). The health home services provided by health homes shall focus on both the behavioral
367.31 and the physical health of these populations.

367.32 Subd. 2. **Eligible individual.** An individual is eligible for health home services
367.33 under this section if the individual is eligible for medical assistance under this chapter
367.34 and has at least:

367.35 (1) two chronic conditions;

368.1 (2) one chronic condition and is at risk of having a second chronic condition; ~~or~~

368.2 (3) one serious and persistent mental health condition~~.~~; or

368.3 (4) a condition that meets the definition in section 245.462, subdivision 20,
368.4 paragraph (a), or 245.4871, subdivision 15, clause (2); and has a current diagnostic
368.5 assessment as defined in Minnesota Rules, part 9505.0372, subpart 1, item B or C, as
368.6 performed or reviewed by a mental health professional employed by or under contract
368.7 with the behavioral health home. The commissioner shall establish criteria for determining
368.8 continued eligibility.

368.9 Subd. 3. **Health home services.** (a) Health home services means comprehensive and
368.10 timely high-quality services that are provided by a health home. These services include:

368.11 (1) comprehensive care management;

368.12 (2) care coordination and health promotion;

368.13 (3) comprehensive transitional care, including appropriate follow-up, from inpatient
368.14 to other settings;

368.15 (4) patient and family support, including authorized representatives;

368.16 (5) referral to community and social support services, if relevant; and

368.17 (6) use of health information technology to link services, as feasible and appropriate.

368.18 (b) The commissioner shall maximize the number and type of services included
368.19 in this subdivision to the extent permissible under federal law, including physician,
368.20 outpatient, mental health treatment, and rehabilitation services necessary for
368.21 comprehensive transitional care following hospitalization.

368.22 Subd. 4. **~~Health teams~~ Designated provider.** (a) Health home services
368.23 are voluntary and an eligible individual may choose any designated provider. The
368.24 commissioner shall establish ~~health teams to support the patient-centered~~ designated
368.25 providers to serve as health ~~home~~ homes and provide the services described in subdivision
368.26 3 to individuals eligible under subdivision 2. The commissioner shall apply for grants ~~or~~
368.27 ~~contracts~~ as provided under section 3502 of the Patient Protection and Affordable Care Act
368.28 to establish health ~~teams~~ homes and provide capitated payments to ~~primary care~~ designated
368.29 providers. For purposes of this section, ~~"health teams"~~ "designated provider" means
368.30 ~~community-based, interdisciplinary, interprofessional teams of health care providers that~~
368.31 ~~support primary care practices. These providers may include medical specialists, nurses,~~
368.32 ~~advanced practice registered nurses, pharmacists, nutritionists, social workers, behavioral~~
368.33 ~~and mental health providers, doctors of chiropractic, licensed complementary and~~
368.34 ~~alternative medicine practitioners, and physician assistants.~~ a provider, clinical practice or
368.35 clinical group practice, rural clinic, community health center, community mental health
368.36 center, or any other entity that is determined by the commissioner to be qualified to be a
369.1 health home for eligible individuals. This determination must be based on documentation
369.2 evidencing that the designated provider has the systems and infrastructure in place to
369.3 provide health home services and satisfies the qualification standards established by the
369.4 commissioner in consultation with stakeholders and approved by the Centers for Medicare
369.5 and Medicaid Services.

369.6 (b) The commissioner shall develop and implement certification standards for
369.7 designated providers under this subdivision.

369.8 Subd. 5. **Payments.** The commissioner shall make payments to each ~~health home~~
369.9 ~~and each health team~~ designated provider for the provision of health home services
369.10 described in subdivision 3 to each eligible individual ~~with chronic conditions~~ under
369.11 subdivision 2 that selects the health home as a provider.

369.12 Subd. 6. **Coordination.** The commissioner, to the extent feasible, shall ensure that
369.13 the requirements and payment methods for ~~health homes and health teams~~ designated
369.14 providers developed under this section are consistent with the requirements and payment
369.15 methods for health care homes established under sections 256B.0751 and 256B.0753. The
369.16 commissioner may modify requirements and payment methods under sections 256B.0751
369.17 and 256B.0753 in order to be consistent with federal health home requirements and
369.18 payment methods.

369.19 Subd. 8. **Evaluation and continued development.** (a) For continued certification
369.20 under this section, health homes must meet process, outcome, and quality standards
369.21 developed and specified by the commissioner. The commissioner shall collect data from
369.22 health homes as necessary to monitor compliance with certification standards.

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369.23 (b) The commissioner may contract with a private entity to evaluate patient and
369.24 family experiences, health care utilization, and costs.

369.25 (c) The commissioner shall utilize findings from the implementation of behavioral
369.26 health homes to determine populations to serve under subsequent health home models
369.27 for individuals with chronic conditions.

369.28 **EFFECTIVE DATE.** This section is effective January 1, 2016, or upon federal
369.29 approval, whichever is later. The commissioner of human services shall notify the revisor
369.30 of statutes when federal approval is obtained.

369.31 Sec. 33. **[256B.0758] HEALTH CARE DELIVERY PILOT PROGRAM.**

369.32 (a) The commissioner may establish a health care delivery pilot program to test
369.33 alternative and innovative integrated health care delivery networks, including accountable
369.34 care organizations or a community-based collaborative care network created by or
370.1 including North Memorial Health Care. If required, the commissioner shall seek federal
370.2 approval of a new waiver request or amend an existing demonstration pilot project waiver.

370.3 (b) Individuals eligible for the pilot program shall be individuals who are eligible for
370.4 medical assistance under section 256B.055. The commissioner may identify individuals
370.5 to be enrolled in the pilot program based on zip code or whether the individuals would
370.6 benefit from an integrated health care delivery network.

370.7 (c) In developing a payment system for the pilot programs, the commissioner shall
370.8 establish a total cost of care for the individuals enrolled in the pilot program that equals
370.9 the cost of care that would otherwise be spent for these enrollees in the prepaid medical
370.10 assistance program.

370.11 (d) The commissioner shall report to the chairs and ranking minority members
370.12 of the legislative committees with jurisdiction over health and human services finance
370.13 committees on whether an integrated health care delivery network was created by North
370.14 Memorial Health Care, including a description of the delivery network system and the
370.15 geographic area served by the network system.

370.16 Sec. 34. Minnesota Statutes 2014, section 256B.69, subdivision 5a, is amended to read:

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

House Language UES1458-1

28.32 Sec. 18. **[256B.0758] HEALTH CARE DELIVERY PILOT PROGRAM.**

28.33 (a) The commissioner may establish a health care delivery pilot program to test
28.34 alternative and innovative integrated health care delivery networks, including accountable
28.35 care organizations or a community-based collaborative care network created by or
29.1 including North Memorial Health Care. If required, the commissioner shall seek federal
29.2 approval of a new waiver request or amend an existing demonstration pilot project waiver.

29.3 (b) Individuals eligible for the pilot program shall be individuals who are eligible for
29.4 medical assistance under section 256B.055. The commissioner may identify individuals
29.5 to be enrolled in the pilot program based on zip code or whether the individuals would
29.6 benefit from an integrated health care delivery network.

29.7 (c) In developing a payment system for the pilot programs, the commissioner shall
29.8 establish a total cost of care for the individuals enrolled in the pilot program that equals
29.9 the cost of care that would otherwise be spent for these enrollees in the prepaid medical
29.10 assistance program.

29.11 Sec. 19. Minnesota Statutes 2014, section 256B.69, subdivision 5a, is amended to read:

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

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

370.26 (c) The commissioner shall withhold five percent of managed care plan payments
370.27 under this section and county-based purchasing plan payments under section 256B.692
370.28 for the prepaid medical assistance program pending completion of performance targets.
370.29 Each performance target must be quantifiable, objective, measurable, and reasonably
370.30 attainable, except in the case of a performance target based on a federal or state law
370.31 or rule. Criteria for assessment of each performance target must be outlined in writing
370.32 prior to the contract effective date. Clinical or utilization performance targets and their
370.33 related criteria must consider evidence-based research and reasonable interventions when
370.34 available or applicable to the populations served, and must be developed with input from
370.35 external clinical experts and stakeholders, including managed care plans, county-based
371.1 purchasing plans, and providers. The managed care or county-based purchasing plan
371.2 must demonstrate, to the commissioner's satisfaction, that the data submitted regarding
371.3 attainment of the performance target is accurate. The commissioner shall periodically
371.4 change the administrative measures used as performance targets in order to improve plan
371.5 performance across a broader range of administrative services. The performance targets
371.6 must include measurement of plan efforts to contain spending on health care services and
371.7 administrative activities. The commissioner may adopt plan-specific performance targets
371.8 that take into account factors affecting only one plan, including characteristics of the
371.9 plan's enrollee population. The withheld funds must be returned no sooner than July of the
371.10 following year if performance targets in the contract are achieved. The commissioner may
371.11 exclude special demonstration projects under subdivision 23.

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

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

29.21 (c) The commissioner shall withhold five percent of managed care plan payments
29.22 under this section and county-based purchasing plan payments under section 256B.692
29.23 for the prepaid medical assistance program pending completion of performance targets.
29.24 Each performance target must be quantifiable, objective, measurable, and reasonably
29.25 attainable, except in the case of a performance target based on a federal or state law
29.26 or rule. Criteria for assessment of each performance target must be outlined in writing
29.27 prior to the contract effective date. Clinical or utilization performance targets and their
29.28 related criteria must consider evidence-based research and reasonable interventions when
29.29 available or applicable to the populations served, and must be developed with input from
29.30 external clinical experts and stakeholders, including managed care plans, county-based
29.31 purchasing plans, and providers. The managed care or county-based purchasing plan
29.32 must demonstrate, to the commissioner's satisfaction, that the data submitted regarding
29.33 attainment of the performance target is accurate. The commissioner shall periodically
29.34 change the administrative measures used as performance targets in order to improve plan
29.35 performance across a broader range of administrative services. The performance targets
30.1 must include measurement of plan efforts to contain spending on health care services and
30.2 administrative activities. The commissioner may adopt plan-specific performance targets
30.3 that take into account factors affecting only one plan, including characteristics of the
30.4 plan's enrollee population. The withheld funds must be returned no sooner than July of the
30.5 following year if performance targets in the contract are achieved. The commissioner may
30.6 exclude special demonstration projects under subdivision 23.

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

371.18 (e) Effective for services rendered on or after January 1, 2012, the commissioner
371.19 shall include as part of the performance targets described in paragraph (c) a reduction
371.20 in the health plan's emergency department utilization rate for medical assistance and
371.21 MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction
371.22 shall be based on the health plan's utilization in 2009. To earn the return of the withhold
371.23 each subsequent year, the managed care plan or county-based purchasing plan must
371.24 achieve a qualifying reduction of no less than ten percent of the plan's emergency
371.25 department utilization rate for medical assistance and MinnesotaCare enrollees, excluding
371.26 enrollees in programs described in subdivisions 23 and 28, compared to the previous
371.27 measurement year until the final performance target is reached. When measuring
371.28 performance, the commissioner must consider the difference in health risk in a managed
371.29 care or county-based purchasing plan's membership in the baseline year compared to the
371.30 measurement year, and work with the managed care or county-based purchasing plan to
371.31 account for differences that they agree are significant.

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

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

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

30.13 (e) Effective for services rendered on or after January 1, 2012, the commissioner
30.14 shall include as part of the performance targets described in paragraph (c) a reduction
30.15 in the health plan's emergency department utilization rate for medical assistance and
30.16 MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction
30.17 shall be based on the health plan's utilization in 2009. To earn the return of the withhold
30.18 each subsequent year, the managed care plan or county-based purchasing plan must
30.19 achieve a qualifying reduction of no less than ten percent of the plan's emergency
30.20 department utilization rate for medical assistance and MinnesotaCare enrollees, excluding
30.21 enrollees in programs described in subdivisions 23 and 28, compared to the previous
30.22 measurement year until the final performance target is reached. When measuring
30.23 performance, the commissioner must consider the difference in health risk in a managed
30.24 care or county-based purchasing plan's membership in the baseline year compared to the
30.25 measurement year, and work with the managed care or county-based purchasing plan to
30.26 account for differences that they agree are significant.

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

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

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

372.21 The withheld funds must be returned no sooner than July 1 and no later than July
372.22 31 of the following calendar year if the managed care plan or county-based purchasing
372.23 plan demonstrates to the satisfaction of the commissioner that this reduction in the
372.24 hospitalization rate was achieved. The commissioner shall structure the withhold so that
372.25 the commissioner returns a portion of the withheld funds in amounts commensurate with
372.26 achieved reductions in utilization less than the targeted amount.

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

372.34 (g) Effective for services rendered on or after January 1, 2012, the commissioner
372.35 shall include as part of the performance targets described in paragraph (c) a reduction in
372.36 the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of
373.1 a previous hospitalization of a patient regardless of the reason, for medical assistance and
373.2 MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the
373.3 withhold each year, the managed care plan or county-based purchasing plan must achieve
373.4 a qualifying reduction of the subsequent hospitalization rate for medical assistance and
373.5 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23
373.6 and 28, of no less than five percent compared to the previous calendar year until the
373.7 final performance target is reached.

373.8 The withheld funds must be returned no sooner than July 1 and no later than July
373.9 31 of the following calendar year if the managed care plan or county-based purchasing
373.10 plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in
373.11 the subsequent hospitalization rate was achieved. The commissioner shall structure the
373.12 withhold so that the commissioner returns a portion of the withheld funds in amounts
373.13 commensurate with achieved reductions in utilization less than the targeted amount.

373.14 The withhold described in this paragraph must continue for each consecutive
373.15 contract period until the plan's subsequent hospitalization rate for medical assistance and
373.16 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23
373.17 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar
373.18 year 2011. Hospitals shall cooperate with the plans in meeting this performance target and
373.19 shall accept payment withholds that must be returned to the hospitals if the performance
373.20 target is achieved.

31.15 The withheld funds must be returned no sooner than July 1 and no later than July
31.16 31 of the following calendar year if the managed care plan or county-based purchasing
31.17 plan demonstrates to the satisfaction of the commissioner that this reduction in the
31.18 hospitalization rate was achieved. The commissioner shall structure the withhold so that
31.19 the commissioner returns a portion of the withheld funds in amounts commensurate with
31.20 achieved reductions in utilization less than the targeted amount.

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

31.28 (g) Effective for services rendered on or after January 1, 2012, the commissioner
31.29 shall include as part of the performance targets described in paragraph (c) a reduction in
31.30 the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of
31.31 a previous hospitalization of a patient regardless of the reason, for medical assistance and
31.32 MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the
31.33 withhold each year, the managed care plan or county-based purchasing plan must achieve
31.34 a qualifying reduction of the subsequent hospitalization rate for medical assistance and
31.35 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23
32.1 and 28, of no less than five percent compared to the previous calendar year until the
32.2 final performance target is reached.

32.3 The withheld funds must be returned no sooner than July 1 and no later than July
32.4 31 of the following calendar year if the managed care plan or county-based purchasing
32.5 plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in
32.6 the subsequent hospitalization rate was achieved. The commissioner shall structure the
32.7 withhold so that the commissioner returns a portion of the withheld funds in amounts
32.8 commensurate with achieved reductions in utilization less than the targeted amount.

32.9 The withhold described in this paragraph must continue for each consecutive
32.10 contract period until the plan's subsequent hospitalization rate for medical assistance and
32.11 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23
32.12 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar
32.13 year 2011. Hospitals shall cooperate with the plans in meeting this performance target and
32.14 shall accept payment withholds that must be returned to the hospitals if the performance
32.15 target is achieved.

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373.21 (h) Effective for services rendered on or after January 1, 2013, through December
373.22 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments
373.23 under this section and county-based purchasing plan payments under section 256B.692
373.24 for the prepaid medical assistance program. The withheld funds must be returned no
373.25 sooner than July 1 and no later than July 31 of the following year. The commissioner may
373.26 exclude special demonstration projects under subdivision 23.

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

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

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

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

374.6 (m) Managed care plans and county-based purchasing plans shall maintain current
374.7 and fully executed agreements for all subcontractors, including bargaining groups, for
374.8 administrative services that are expensed to the state's public health care programs.
374.9 Subcontractor agreements of over $200,000 in annual payments must be in the form of a
374.10 written instrument or electronic document containing the elements of offer, acceptance,
374.11 and consideration, and must clearly indicate how they relate to state public health
374.12 care programs. Upon request, the commissioner shall have access to all subcontractor
374.13 documentation under this paragraph. Nothing in this paragraph shall allow release of
374.14 information that is nonpublic data pursuant to section 13.02.

374.15 Sec. 35. Minnesota Statutes 2014, section 256B.69, subdivision 5i, is amended to read:

House Language UES1458-1

32.16 (h) Effective for services rendered on or after January 1, 2013, through December
32.17 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments
32.18 under this section and county-based purchasing plan payments under section 256B.692
32.19 for the prepaid medical assistance program. The withheld funds must be returned no
32.20 sooner than July 1 and no later than July 31 of the following year. The commissioner may
32.21 exclude special demonstration projects under subdivision 23.

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

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

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

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

33.1 (m) Managed care plans and county-based purchasing plans shall maintain current
33.2 and fully executed agreements for all subcontractors, including bargaining groups, for
33.3 administrative services that are expensed to the state's public programs. Subcontractor
33.4 agreements of over $200,000 in annual payments must be in the form of a written
33.5 instrument or electronic document containing the elements of offer, acceptance, and
33.6 consideration, and must clearly indicate how the agreements relate to state public
33.7 programs. Upon request, the commissioner shall have access to all subcontractor
33.8 documentation under this paragraph. Nothing in this paragraph shall allow release of
33.9 information that is nonpublic data pursuant to section 13.02.

33.10 Sec. 20. Minnesota Statutes 2014, section 256B.69, subdivision 5i, is amended to read:

Senate Language S1458-2

374.16 Subd. 5i. **Administrative expenses.** (a) ~~Managed care plan and county-based~~
374.17 ~~purchasing plan~~ Administrative costs ~~for a prepaid health plan provided~~ paid to managed
374.18 care plans and county-based purchasing plans under this section ~~or~~, section 256B.692,
374.19 and section 256L.12 must not exceed ~~by more than five~~ 6.6 percent ~~that prepaid health~~
374.20 ~~plan's or county-based purchasing plan's actual calculated administrative spending for the~~
374.21 ~~previous calendar year as a percentage of total revenue~~ of total payments made to all
374.22 managed care plans and county-based purchasing plans in aggregate across all state public
374.23 health care programs, based on payments expected to be made at the beginning of each
374.24 calendar year. ~~The penalty for exceeding this limit must be the amount of administrative~~
374.25 ~~spending in excess of 105 percent of the actual calculated amount. The commissioner may~~
374.26 ~~waive this penalty if the excess administrative spending is the result of unexpected shifts~~
374.27 ~~in enrollment or member needs or new program requirements.~~ The commissioner may
374.28 reduce or eliminate administrative requirements to meet the administrative cost limit.
374.29 For purposes of this paragraph, administrative costs do not include any state or federal
374.30 taxes, surcharges, or assessments.

374.31 (b) The following expenses are not allowable administrative expenses for rate-setting
374.32 purposes under this section:

374.33 (1) charitable contributions made by the managed care plan or the county-based
374.34 purchasing plan;

375.1 (2) ~~any portion of an individual's compensation in excess of $200,000 paid by the~~
375.2 ~~managed care plan or county-based purchasing plan~~ compensation of individuals within
375.3 the organization in excess of $200,000 such that the allocation of compensation for an
375.4 individual across all state public health care programs in total cannot exceed $200,000;

375.5 (3) any penalties or fines assessed against the managed care plan or county-based
375.6 purchasing plan; ~~and~~

375.7 (4) any indirect marketing or advertising expenses of the managed care plan or
375.8 county-based purchasing plan~~.~~ for marketing that does not specifically target state public
375.9 health care programs beneficiaries and that has not been approved by the commissioner;

375.10 (5) any lobbying and political activities, events, or contributions;

375.11 (6) administrative expenses related to the provision of services not covered under
375.12 the state plan or waiver;

375.13 (7) alcoholic beverages and related costs;

375.14 (8) membership in any social, dining, or country club or organization; and

375.15 (9) entertainment, including amusement, diversion, and social activities, and any
375.16 costs directly associated with these costs, including but not limited to tickets to shows or
375.17 sporting events, meals, lodging, rentals, transportation, and gratuities.

House Language UES1458-1

33.11 Subd. 5i. **Administrative expenses.** (a) ~~Managed care plan and county-based~~
33.12 ~~purchasing plan~~ Administrative costs ~~for a prepaid health plan provided~~ paid to managed
33.13 care plans and county-based purchasing plans under this section ~~or~~, section 256B.692, and
33.14 section 256L.12 must not exceed ~~by more than five~~ 6.6 percent ~~that prepaid health plan's or~~
33.15 ~~county-based purchasing plan's actual calculated administrative spending for the previous~~
33.16 ~~calendar year as a percentage of total revenue~~ of total payments expected to be made to
33.17 all managed care plans and county-based purchasing plans in aggregate across all state
33.18 public programs at the beginning of each calendar year. ~~The penalty for exceeding this~~
33.19 ~~limit must be the amount of administrative spending in excess of 105 percent of the actual~~
33.20 ~~calculated amount. The commissioner may waive this penalty if the excess administrative~~
33.21 ~~spending is the result of unexpected shifts in enrollment or member needs or new program~~
33.22 ~~requirements.~~ The commissioner may reduce or eliminate administrative requirements to
33.23 meet the administrative cost limit. For purposes of this paragraph, administrative costs do
33.24 not include any state or federal taxes, surcharges, or assessments.

33.25 (b) The following expenses are not allowable administrative expenses for rate-setting
33.26 purposes under this section:

33.27 (1) charitable contributions made by the managed care plan or the county-based
33.28 purchasing plan;

33.29 (2) ~~any portion of an individual's compensation in excess of $200,000 paid by the~~
33.30 ~~managed care plan or county-based purchasing plan~~ compensation of individuals within
33.31 the organization, other than the medical director, in excess of $200,000 such that the
33.32 allocation of compensation for an individual across all state public programs in total
33.33 cannot exceed $200,000;

33.34 (3) any penalties or fines assessed against the managed care plan or county-based
33.35 purchasing plan; ~~and~~

34.1 (4) any indirect marketing or advertising expenses of the managed care plan or
34.2 county-based purchasing plan~~.~~ for marketing that does not specifically target state public
34.3 programs beneficiaries and that has not been approved by the commissioner;

34.4 (5) any lobbying and political activities, events, or contributions;

34.5 (6) administrative expenses related to the provision of services not covered under
34.6 the state plan or waiver;

34.7 (7) alcoholic beverages and related costs;

34.8 (8) membership in any social, dining, or country club or organization; and

34.9 (9) entertainment, including amusement, diversion, and social activities, and any
34.10 costs directly associated with these costs, including but not limited to tickets to shows or
34.11 sporting events, meals, lodging, rentals, transportation, and gratuities.

Senate Language S1458-2

375.18 For the purposes of this subdivision, compensation includes salaries, bonuses and
375.19 incentives, other reportable compensation on an IRS 990 form, retirement and other
375.20 deferred compensation, and nontaxable benefits. Contributions include payments for or to
375.21 any organization or entity selected by the managed care plan or county-based purchasing
375.22 plan that is operated for charitable, educational, political, religious, or scientific purposes
375.23 and not related to the provision of medical and administrative services covered under the
375.24 state public programs, except to the extent that they improve access to or the quality of
375.25 covered services for state public programs beneficiaries, or improve the health status of
375.26 state public health care programs beneficiaries.

375.27 (c) Administrative expenses must be reported using the formats designated by the
375.28 commissioner as part of the rate-setting process and must include, at a minimum, the
375.29 following categories:

375.30 (1) employee benefit expenses;

375.31 (2) sales expenses;

375.32 (3) general business and office expenses;

375.33 (4) taxes and assessments;

375.34 (5) consulting and professional fees; and

375.35 (6) outsourced services.

376.1 Definitions of items to be included in each category shall be provided by the commissioner
376.2 with quarterly financial filing requirements and shall be aligned with definitions used by
376.3 the Departments of Commerce and Health in financial reporting for commercial carriers.
376.4 Where reasonably possible, expenses for an administrative item shall be directly allocated
376.5 so as to assign costs for an item to an individual state public health care program when
376.6 the cost can be specifically identified with and benefits the individual state public health
376.7 care program. For administrative services expensed to the state's public health care
376.8 programs, managed care plans and county-based purchasing plans must clearly identify
376.9 and separately record expense items listed under paragraph (b) in their accounting systems
376.10 in a manner that allows for independent verification of unallowable expenses for purposes
376.11 of determining payment rates for state public programs.

House Language UES1458-1

34.12 For the purposes of this subdivision, compensation includes salaries, bonuses and
34.13 incentives, other reportable compensation on an IRS 990 form, retirement and other
34.14 deferred compensation, and nontaxable benefits. Contributions include payments for
34.15 or to any organization or entity selected by the health maintenance organization that
34.16 is operated for charitable, educational, political, religious, or scientific purposes and
34.17 not related to the provision of medical and administrative services covered under the
34.18 state public programs, except to the extent that they improve access to or the quality of
34.19 covered services for state public programs beneficiaries, or improve the health status of
34.20 state public programs beneficiaries.

34.21 (c) Administrative expenses must be reported using the formats designated by the
34.22 commissioner as part of the rate-setting process and must include, at a minimum, the
34.23 following categories:

34.24 (1) employee benefit expenses;

34.25 (2) sales expenses;

34.26 (3) general business and office expenses;

34.27 (4) taxes and assessments;

34.28 (5) consulting and professional fees; and

34.29 (6) outsourced services.

34.30 Definitions of items to be included in each category shall be provided by the commissioner
34.31 with quarterly financial filing requirements and shall be aligned with definitions used
34.32 by the Departments of Commerce and Health in financial reporting for commercial
34.33 carriers. Where reasonably possible, expenses for an administrative item shall be directly
34.34 allocated so as to assign costs for an item to an individual state public program when the
34.35 cost can be specifically identified with and benefits the individual state public program.
34.36 For administrative services expensed to the state's public programs, managed care plans
35.1 and county-based purchasing plans must clearly identify and separately record expense
35.2 items listed under paragraph (b) in their accounting systems in a manner that allows for
35.3 independent verification of unallowable expenses for purposes of determining payment
35.4 rates for state public programs.

Senate Language S1458-2

376.12 (d) Notwithstanding paragraph (a), the commissioner shall reduce administrative
376.13 expenses paid to managed care plans and county-based purchasing plans by .56 of a
376.14 percentage point for contracts beginning January 1, 2016, and ending December 31, 2017;
376.15 and by .77 of a percentage point for contracts beginning January 1, 2018, and ending
376.16 December 31, 2019. To meet the administrative reductions under this paragraph, the
376.17 commissioner may reduce or eliminate administrative requirements, exclude additional
376.18 unallowable administrative expenses identified under this section and resulting from the
376.19 financial audits conducted under subdivision 9d, and utilize competitive bidding to gain
376.20 efficiencies through economies of scale from increased enrollment. If the total reduction
376.21 cannot be achieved through administrative reduction, the commissioner may limit total
376.22 rate increases on payments to managed care plans and county-based purchasing plans.

376.23 Sec. 36. Minnesota Statutes 2014, section 256B.69, subdivision 9c, is amended to read:

376.24 Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect
376.25 detailed data regarding financials, provider payments, provider rate methodologies, and
376.26 other data as determined by the commissioner. The commissioner, in consultation with the
376.27 commissioners of health and commerce, and in consultation with managed care plans and
376.28 county-based purchasing plans, shall set uniform criteria, definitions, and standards for the
376.29 data to be submitted, and shall require managed care and county-based purchasing plans
376.30 to comply with these criteria, definitions, and standards when submitting data under this
376.31 section. In carrying out the responsibilities of this subdivision, the commissioner shall
376.32 ensure that the data collection is implemented in an integrated and coordinated manner
376.33 that avoids unnecessary duplication of effort. To the extent possible, the commissioner
376.34 shall use existing data sources and streamline data collection in order to reduce public
377.1 and private sector administrative costs. Nothing in this subdivision shall allow release of
377.2 information that is nonpublic data pursuant to section 13.02.

377.3 (b) Effective January 1, 2014, each managed care and county-based purchasing plan
377.4 must quarterly provide to the commissioner the following information on state public
377.5 programs, in the form and manner specified by the commissioner, according to guidelines
377.6 developed by the commissioner in consultation with managed care plans and county-based
377.7 purchasing plans under contract:

377.8 (1) an income statement by program;

377.9 (2) financial statement footnotes;

377.10 (3) quarterly profitability by program and population group;

377.11 (4) a medical liability summary by program and population group;

377.12 (5) received but unpaid claims report by program;

House Language UES1458-1

35.5 (d) The administrative expenses requirement of this subdivision also apply to
35.6 demonstration providers under section 256B.0755.

35.7 Sec. 21. Minnesota Statutes 2014, section 256B.69, subdivision 9c, is amended to read:

35.8 Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect
35.9 detailed data regarding financials, provider payments, provider rate methodologies, and
35.10 other data as determined by the commissioner. The commissioner, in consultation with the
35.11 commissioners of health and commerce, and in consultation with managed care plans and
35.12 county-based purchasing plans, shall set uniform criteria, definitions, and standards for the
35.13 data to be submitted, and shall require managed care and county-based purchasing plans
35.14 to comply with these criteria, definitions, and standards when submitting data under this
35.15 section. In carrying out the responsibilities of this subdivision, the commissioner shall
35.16 ensure that the data collection is implemented in an integrated and coordinated manner
35.17 that avoids unnecessary duplication of effort. To the extent possible, the commissioner
35.18 shall use existing data sources and streamline data collection in order to reduce public
35.19 and private sector administrative costs. Nothing in this subdivision shall allow release of
35.20 information that is nonpublic data pursuant to section 13.02.

35.21 (b) Effective January 1, 2014, each managed care and county-based purchasing plan
35.22 must quarterly provide to the commissioner the following information on state public
35.23 programs, in the form and manner specified by the commissioner, according to guidelines
35.24 developed by the commissioner in consultation with managed care plans and county-based
35.25 purchasing plans under contract:

35.26 (1) an income statement by program;

35.27 (2) financial statement footnotes;

35.28 (3) quarterly profitability by program and population group;

35.29 (4) a medical liability summary by program and population group;

35.30 (5) received but unpaid claims report by program;

Senate Language S1458-2

377.13 (6) services versus payment lags by program for hospital services, outpatient
377.14 services, physician services, other medical services, and pharmaceutical benefits;

377.15 (7) utilization reports that summarize utilization and unit cost information by
377.16 program for hospitalization services, outpatient services, physician services, and other
377.17 medical services;

377.18 (8) pharmaceutical statistics by program and population group for measures of price
377.19 and utilization of pharmaceutical services;

377.20 (9) subcapitation expenses by population group;

377.21 (10) third-party payments by program;

377.22 (11) all new, active, and closed subrogation cases by program;

377.23 (12) all new, active, and closed fraud and abuse cases by program;

377.24 (13) medical loss ratios by program;

377.25 (14) administrative expenses by category and subcategory by program that reconcile
377.26 to other state and federal regulatory agencies;

377.27 (15) revenues by program, including investment income;

377.28 (16) nonadministrative service payments, provider payments, and reimbursement
377.29 rates by provider type or service category, by program, paid by the managed care plan
377.30 under this section or the county-based purchasing plan under section 256B.692 to
377.31 providers and vendors for administrative services under contract with the plan, including
377.32 but not limited to:

377.33 (i) individual-level provider payment and reimbursement rate data;

377.34 (ii) provider reimbursement rate methodologies by provider type, by program,
377.35 including a description of alternative payment arrangements and payments outside the
377.36 claims process;

378.1 (iii) data on implementation of legislatively mandated provider rate changes; and

378.2 (iv) individual-level provider payment and reimbursement rate data and plan-specific
378.3 provider reimbursement rate methodologies by provider type, by program, including
378.4 alternative payment arrangements and payments outside the claims process, provided to
378.5 the commissioner under this subdivision are nonpublic data as defined in section 13.02;

378.6 (17) data on the amount of reinsurance or transfer of risk by program; and

378.7 (18) contribution to reserve, by program.

House Language UES1458-1

35.31 (6) services versus payment lags by program for hospital services, outpatient
35.32 services, physician services, other medical services, and pharmaceutical benefits;

35.33 (7) utilization reports that summarize utilization and unit cost information by
35.34 program for hospitalization services, outpatient services, physician services, and other
35.35 medical services;

36.1 (8) pharmaceutical statistics by program and population group for measures of price
36.2 and utilization of pharmaceutical services;

36.3 (9) subcapitation expenses by population group;

36.4 (10) third-party payments by program;

36.5 (11) all new, active, and closed subrogation cases by program;

36.6 (12) all new, active, and closed fraud and abuse cases by program;

36.7 (13) medical loss ratios by program;

36.8 (14) administrative expenses by category and subcategory by program that reconcile
36.9 to other state and federal regulatory agencies;

36.10 (15) revenues by program, including investment income;

36.11 (16) nonadministrative service payments, provider payments, and reimbursement
36.12 rates by provider type or service category, by program, paid by the managed care plan
36.13 under this section or the county-based purchasing plan under section 256B.692 to
36.14 providers and vendors for administrative services under contract with the plan, including
36.15 but not limited to:

36.16 (i) individual-level provider payment and reimbursement rate data;

36.17 (ii) provider reimbursement rate methodologies by provider type, by program,
36.18 including a description of alternative payment arrangements and payments outside the
36.19 claims process;

36.20 (iii) data on implementation of legislatively mandated provider rate changes; and

36.21 (iv) individual-level provider payment and reimbursement rate data and plan-specific
36.22 provider reimbursement rate methodologies by provider type, by program, including
36.23 alternative payment arrangements and payments outside the claims process, provided to
36.24 the commissioner under this subdivision are nonpublic data as defined in section 13.02;

36.25 (17) data on the amount of reinsurance or transfer of risk by program; and

36.26 (18) contribution to reserve, by program.

Senate Language S1458-2

378.8 (c) In the event a report is published or released based on data provided under
378.9 this subdivision, the commissioner shall provide the report to managed care plans and
378.10 county-based purchasing plans 15 days prior to the publication or release of the report.
378.11 Managed care plans and county-based purchasing plans shall have 15 days to review the
378.12 report and provide comment to the commissioner.

378.13 The quarterly reports shall be submitted to the commissioner no later than 60 days after the
378.14 end of the previous quarter, except the fourth-quarter report, which shall be submitted by
378.15 April 1 of each year. The fourth-quarter report shall include audited financial statements,
378.16 parent company audited financial statements, an income statement reconciliation report,
378.17 and any other documentation necessary to reconcile the detailed reports to the audited
378.18 financial statements.

378.19 (d) Managed care plans and county-based purchasing plans shall certify to the
378.20 commissioner for the purpose of financial reporting for state public health care programs
378.21 under this subdivision that costs reported for state public health care programs include:

378.22 (1) only services covered under the state plan and waivers, and related allowable
378.23 administrative expenses; and

378.24 (2) the dollar value of unallowable and nonstate plan services, including both
378.25 medical and administrative expenditures, that have been excluded.

378.26 Sec. 37. Minnesota Statutes 2014, section 256B.69, subdivision 9d, is amended to read:

378.27 Subd. 9d. **Financial ~~audit~~ and quality assurance audits.** ~~(a) The legislative~~
378.28 ~~auditor shall contract with an audit firm to conduct a biennial independent third-party~~
378.29 ~~financial audit of the information required to be provided by managed care plans and~~
378.30 ~~county-based purchasing plans under subdivision 9c, paragraph (b). The audit shall be~~
378.31 ~~conducted in accordance with generally accepted government auditing standards issued~~
378.32 ~~by the United States Government Accountability Office. The contract with the audit~~
378.33 ~~firm shall be designed and administered so as to render the independent third-party audit~~
378.34 ~~eligible for a federal subsidy, if available. The contract shall require the audit to include~~
378.35 ~~a determination of compliance with the federal Medicaid rate certification process. The~~
379.1 ~~contract shall require the audit to determine if the administrative expenses and investment~~
379.2 ~~income reported by the managed care plans and county-based purchasing plans are~~
379.3 ~~compliant with state and federal law.~~

379.4 ~~(b) For purposes of this subdivision, "independent third party" means an audit firm~~
379.5 ~~that is independent in accordance with government auditing standards issued by the United~~
379.6 ~~States Government Accountability Office and licensed in accordance with chapter 326A.~~
379.7 ~~An audit firm under contract to provide services in accordance with this subdivision must~~
379.8 ~~not have provided services to a managed care plan or county-based purchasing plan during~~
379.9 ~~the period for which the audit is being conducted.~~

House Language UES1458-1

36.27 (c) In the event a report is published or released based on data provided under
36.28 this subdivision, the commissioner shall provide the report to managed care plans and
36.29 county-based purchasing plans 15 days prior to the publication or release of the report.
36.30 Managed care plans and county-based purchasing plans shall have 15 days to review the
36.31 report and provide comment to the commissioner.

36.32 The quarterly reports shall be submitted to the commissioner no later than 60 days after the
36.33 end of the previous quarter, except the fourth-quarter report, which shall be submitted by
36.34 April 1 of each year. The fourth-quarter report shall include audited financial statements,
36.35 parent company audited financial statements, an income statement reconciliation report,
37.1 and any other documentation necessary to reconcile the detailed reports to the audited
37.2 financial statements.

37.3 (d) Managed care plans and county-based purchasing plans shall certify to the
37.4 commissioner, for the purpose of managed care financial reporting for state public
37.5 health care programs under this subdivision, that costs related to state public health care
37.6 programs include only services covered under the state plan and waivers, and related
37.7 allowable administrative expenses. Managed care plans and county-based purchasing
37.8 plans shall certify and report to the commissioner the dollar value of any unallowable and
37.9 nonstate plan services, including both medical and administrative expenditures, for the
37.10 purposes of managed care financial reporting under this subdivision.

37.11 (e) The financial reporting requirements of this subdivision also apply to
37.12 demonstration providers under section 256B.0755.

37.13 Sec. 22. Minnesota Statutes 2014, section 256B.69, subdivision 9d, is amended to read:

37.14 Subd. 9d. **Financial ~~audit~~ and quality assurance audits.** ~~(a) The legislative~~
37.15 ~~auditor shall contract with an audit firm to conduct a biennial independent third-party~~
37.16 ~~financial audit of the information required to be provided by managed care plans and~~
37.17 ~~county-based purchasing plans under subdivision 9c, paragraph (b). The audit shall be~~
37.18 ~~conducted in accordance with generally accepted government auditing standards issued~~
37.19 ~~by the United States Government Accountability Office. The contract with the audit~~
37.20 ~~firm shall be designed and administered so as to render the independent third-party audit~~
37.21 ~~eligible for a federal subsidy, if available. The contract shall require the audit to include~~
37.22 ~~a determination of compliance with the federal Medicaid rate certification process. The~~
37.23 ~~contract shall require the audit to determine if the administrative expenses and investment~~
37.24 ~~income reported by the managed care plans and county-based purchasing plans are~~
37.25 ~~compliant with state and federal law.~~

37.26 ~~(b) For purposes of this subdivision, "independent third party" means an audit firm~~
37.27 ~~that is independent in accordance with government auditing standards issued by the United~~
37.28 ~~States Government Accountability Office and licensed in accordance with chapter 326A.~~
37.29 ~~An audit firm under contract to provide services in accordance with this subdivision must~~
37.30 ~~not have provided services to a managed care plan or county-based purchasing plan during~~
37.31 ~~the period for which the audit is being conducted.~~

379.10 (c) (a) The commissioner shall require, in the request for bids and resulting contracts
379.11 with managed care plans and county-based purchasing plans under this section and
379.12 section 256B.692, that each managed care plan and county-based purchasing plan submit
379.13 to and fully cooperate with the independent third-party financial audit audits by the
379.14 legislative auditor under subdivision 9e of the information required under subdivision 9c,
379.15 paragraph (b). Each contract with a managed care plan or county-based purchasing plan
379.16 under this section or section 256B.692 must provide the commissioner and the audit firm
379.17 vendors contracting with the legislative auditor access to all data required to complete
379.18 the audit. For purposes of this subdivision, the contracting audit firm shall have the same
379.19 investigative power as the legislative auditor under section 3.978, subdivision 2 audits
379.20 under subdivision 9e.

379.21 (d) (b) Each managed care plan and county-based purchasing plan providing services
379.22 under this section shall provide to the commissioner biweekly encounter data and claims
379.23 data for state public health care programs and shall participate in a quality assurance
379.24 program that verifies the timeliness, completeness, accuracy, and consistency of the data
379.25 provided. The commissioner shall develop written protocols for the quality assurance
379.26 program and shall make the protocols publicly available. The commissioner shall contract
379.27 for an independent third-party audit to evaluate the quality assurance protocols as to
379.28 the capacity of the protocols to ensure complete and accurate data and to evaluate the
379.29 commissioner's implementation of the protocols. The audit firm under contract to provide
379.30 this evaluation must meet the requirements in paragraph (b).

379.31 (e) Upon completion of the audit under paragraph (a) and receipt by the legislative
379.32 auditor, the legislative auditor shall provide copies of the audit report to the commissioner,
379.33 the state auditor, the attorney general, and the chairs and ranking minority members of the
379.34 health and human services finance committees of the legislature. (c) Upon completion
379.35 of the evaluation under paragraph (d) (b), the commissioner shall provide copies of the
379.36 report to the legislative auditor and the chairs and ranking minority members of the health
380.1 finance committees of the legislature legislative committees with jurisdiction over health
380.2 care policy and financing.

380.3 (f) (d) Any actuary under contract with the commissioner to provide actuarial
380.4 services must meet the independence requirements under the professional code for fellows
380.5 in the Society of Actuaries and must not have provided actuarial services to a managed
380.6 care plan or county-based purchasing plan that is under contract with the commissioner
380.7 pursuant to this section and section 256B.692 during the period in which the actuarial
380.8 services are being provided. An actuary or actuarial firm meeting the requirements
380.9 of this paragraph must certify and attest to the rates paid to the managed care plans
380.10 and county-based purchasing plans under this section and section 256B.692, and the
380.11 certification and attestation must be auditable.

37.32 (c) (a) The commissioner shall require, in the request for bids and resulting contracts
37.33 with managed care plans and county-based purchasing plans under this section and
37.34 section 256B.692, that each managed care plan and county-based purchasing plan submit
37.35 to and fully cooperate with the independent third-party financial audit audits by the
38.1 legislative auditor under subdivision 9e of the information required under subdivision 9c,
38.2 paragraph (b). Each contract with a managed care plan or county-based purchasing plan
38.3 under this section or section 256B.692 must provide the commissioner and the audit firm
38.4 vendors contracting with the legislative auditor access to all data required to complete
38.5 the audit. For purposes of this subdivision, the contracting audit firm shall have the same
38.6 investigative power as the legislative auditor under section 3.978, subdivision 2 audits
38.7 under subdivision 9e.

38.8 (d) (b) Each managed care plan and county-based purchasing plan providing services
38.9 under this section shall provide to the commissioner biweekly encounter data and claims
38.10 data for state public health care programs and shall participate in a quality assurance
38.11 program that verifies the timeliness, completeness, accuracy, and consistency of the data
38.12 provided. The commissioner shall develop written protocols for the quality assurance
38.13 program and shall make the protocols publicly available. The commissioner shall contract
38.14 for an independent third-party audit to evaluate the quality assurance protocols as to
38.15 the capacity of the protocols to ensure complete and accurate data and to evaluate the
38.16 commissioner's implementation of the protocols. The audit firm under contract to provide
38.17 this evaluation must meet the requirements in paragraph (b).

38.18 (e) Upon completion of the audit under paragraph (a) and receipt by the legislative
38.19 auditor, the legislative auditor shall provide copies of the audit report to the commissioner,
38.20 the state auditor, the attorney general, and the chairs and ranking minority members of the
38.21 health and human services finance committees of the legislature. (c) Upon completion
38.22 of the evaluation under paragraph (d) (b), the commissioner shall provide copies of the
38.23 report to the legislative auditor and the chairs and ranking minority members of the health
38.24 finance committees of the legislature legislative committees with jurisdiction over health
38.25 care policy and financing.

38.26 (f) (d) Any actuary under contract with the commissioner to provide actuarial
38.27 services must meet the independence requirements under the professional code for fellows
38.28 in the Society of Actuaries and must not have provided actuarial services to a managed
38.29 care plan or county-based purchasing plan that is under contract with the commissioner
38.30 pursuant to this section and section 256B.692 during the period in which the actuarial
38.31 services are being provided. An actuary or actuarial firm meeting the requirements
38.32 of this paragraph must certify and attest to the rates paid to the managed care plans
38.33 and county-based purchasing plans under this section and section 256B.692, and the
38.34 certification and attestation must be auditable.

Senate Language S1458-2

380.12 (e) The commissioner may conduct ad hoc audits of the state public health care
380.13 programs administrative and medical expenses of managed care plans and county-based
380.14 purchasing plans. This includes: financial and encounter data reported to the commissioner
380.15 under subdivision 9c, including payments to providers and subcontractors; supporting
380.16 documentation for expenditures; categorization of administrative and medical expenses;
380.17 and allocation methods used to attribute administrative expenses to state public health
380.18 care programs. These audits also must monitor compliance with data and financial
380.19 certifications provided to the commissioner for the purposes of managed care capitation
380.20 payment rate-setting. The managed care plans and county-based purchasing plans shall
380.21 fully cooperate with the audits in this subdivision.

380.22 ~~(g)~~ (f) Nothing in this subdivision shall allow the release of information that is
380.23 nonpublic data pursuant to section 13.02.

380.24 Sec. 38. Minnesota Statutes 2014, section 256B.69, is amended by adding a
380.25 subdivision to read:

380.26 Subd. 9e. **Financial audits.** (a) The legislative auditor shall contract with vendors
380.27 to conduct independent third-party financial audits of the information required to be
380.28 provided by managed care plans and county-based purchasing plans under subdivision
380.29 9c, paragraph (b). The audits by the vendors shall be conducted as vendor resources
380.30 permit and in accordance with generally accepted government auditing standards issued
380.31 by the United States Government Accountability Office. The contract with the vendors
380.32 shall be designed and administered so as to render the independent third-party audits
380.33 eligible for a federal subsidy, if available. The contract shall require the audits to include a
380.34 determination of compliance with the federal Medicaid rate certification process.

381.1 (b) For purposes of this subdivision, "independent third-party" means a vendor that
381.2 is independent in accordance with government auditing standards issued by the United
381.3 States Government Accountability Office.

381.4 Sec. 39. **[256B.695] DENTAL SERVICES UTILIZATION MEASURES.**

381.5 Subdivision 1. **Access benchmarks.** The commissioner shall evaluate access to
381.6 dental services for children and adults enrolled in medical assistance and MinnesotaCare
381.7 using the following measurements:

381.8 (1) the percentage of enrollees that have access to nonspecialty dental services within
381.9 a 60-minute or 60-mile radius of the enrollee's residence through an analysis of utilization
381.10 data from claims submitted to determine the service location, and by other appropriate
381.11 means. This measurement shall be determined in the aggregate and by each individual
381.12 payer, including the state and each managed care plan and county-based purchasing plan;

House Language UES1458-1

38.35 (e) The commissioner may conduct ad hoc audits of the state public programs
38.36 administrative and medical expenses of managed care organizations and county-based
39.1 purchasing plans. This includes: financial and encounter data reported to the commissioner
39.2 under subdivision 9c, including payments to providers and subcontractors; supporting
39.3 documentation for expenditures; categorization of administrative and medical expenses;
39.4 and allocation methods used to attribute administrative expenses to state public programs.
39.5 These audits also must monitor compliance with data and financial certifications provided
39.6 to the commissioner for the purposes of managed care capitation payment rate-setting.
39.7 The managed care plans and county-based purchasing plans shall fully cooperate with the
39.8 audits in this subdivision.

39.9 ~~(g)~~ (f) Nothing in this subdivision shall allow the release of information that is
39.10 nonpublic data pursuant to section 13.02.

39.11 (g) The audit requirements of this subdivision also apply to demonstration providers
39.12 under section 256B.0755.

39.13 Sec. 23. Minnesota Statutes 2014, section 256B.69, is amended by adding a
39.14 subdivision to read:

39.15 Subd. 9e. **Financial audits.** (a) The legislative auditor shall contract with vendors
39.16 to conduct independent third-party financial audits of the Department of Human Services'
39.17 use of the information required to be provided by managed care plans and county-based
39.18 purchasing plans under subdivision 9c, paragraph (b). The audits by the vendors shall
39.19 be conducted as vendor resources permit and in accordance with generally accepted
39.20 government auditing standards issued by the United States Government Accountability
39.21 Office. The contract with the vendors shall be designed and administered so as to render
39.22 the independent third-party audits eligible for a federal subsidy, if available. The contract
39.23 shall require the audits to include a determination of compliance by the Department of
39.24 Human Services with the federal Medicaid rate certification process.

39.25 (b) For purposes of this subdivision, "independent third-party" means a vendor that
39.26 is independent in accordance with government auditing standards issued by the United
39.27 States Government Accountability Office.

381.13 (2) the percentage of adult enrollees continuously enrolled for at least six months in
381.14 a calendar year receiving an oral health evaluation within the year measured; and

381.15 (3) the percentage of children under the age of 21 continuously enrolled for at least
381.16 90 days in a calendar year receiving, within the year measured:

381.17 (i) an oral health evaluation and sealants; and

381.18 (ii) follow-up care after an oral health evaluation.

381.19 Subd. 2. **Baseline measurement.** The commissioner shall establish a baseline
381.20 measurement on access to dental services using the measures in subdivision 1 for enrollees
381.21 receiving dental services through the fee-for-service system and through managed care
381.22 plans or county-based purchasing plans. The baseline shall be calculated using calendar
381.23 year 2014 as the base year.

381.24 Subd. 3. **Access improvement goals.** (a) By April 1, 2017, the commissioner
381.25 shall calculate the measures described in subdivision 1 using fiscal year 2016, compare
381.26 these measures with the baseline measures calculated under subdivision 2, and submit
381.27 to the legislature the comparison results.

381.28 (b) If each measure described in subdivision 1, clauses (1), (2), and (3), has not
381.29 increased by at least 20 percent, the dental competitive bidding system described in
381.30 subdivision 4 shall be implemented by the commissioner if the legislature, by law, ratifies
381.31 its implementation after receipt of the calculations described in paragraph (a).

381.32 Subd. 4. **Dental competitive bidding system.** (a) Effective for dental services
381.33 rendered on or after January 1, 2019, the commissioner shall contract through a
381.34 competitive bidding process with a qualified entity or entities to directly administer
381.35 the delivery of dental services to all state public health care program enrollees. The
382.1 contracting entity or entities shall administer all dental services currently provided through
382.2 the fee-for-service system, managed care plans, and county-based purchasing plans.

382.3 (b) The commissioner may contract with a health care delivery system established
382.4 under section 256B.0755 or 256B.0756, or a county-based purchasing plan to receive
382.5 payment on a prospective per capita basis or through an alternative mutually agreed to
382.6 arrangement. The payment must be based on activities and outcomes directly related
382.7 to recruitment of dentists and outreach to state public health care program enrollees
382.8 residing within a designated geographic area. The contracted activities must be done in
382.9 coordination with the contracted administrator under paragraph (a) and the commissioner.
382.10 The commissioner shall contract with one entity under this paragraph to perform these
382.11 services within any designated geographic area.

382.12 Sec. 40. Minnesota Statutes 2014, section 256B.75, is amended to read:
382.13 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

39.28 Sec. 24. Minnesota Statutes 2014, section 256B.75, is amended to read:
39.29 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

Senate Language S1458-2

382.14 (a) For outpatient hospital facility fee payments for services rendered on or after
382.15 October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted
382.16 charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those
382.17 services for which there is a federal maximum allowable payment. Effective for services
382.18 rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital
382.19 facility fees and emergency room facility fees shall be increased by eight percent over the
382.20 rates in effect on December 31, 1999, except for those services for which there is a federal
382.21 maximum allowable payment. Services for which there is a federal maximum allowable
382.22 payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum
382.23 allowable payment. Total aggregate payment for outpatient hospital facility fee services
382.24 shall not exceed the Medicare upper limit. If it is determined that a provision of this
382.25 section conflicts with existing or future requirements of the United States government with
382.26 respect to federal financial participation in medical assistance, the federal requirements
382.27 prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to
382.28 avoid reduced federal financial participation resulting from rates that are in excess of
382.29 the Medicare upper limitations.

382.30 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and
382.31 ambulatory surgery hospital facility fee services for critical access hospitals designated
382.32 under section 144.1483, clause (9), shall be paid on a cost-based payment system that is
382.33 based on the cost-finding methods and allowable costs of the Medicare program. Effective
382.34 for services provided on or after July 1, 2015, rates established for critical access hospitals
383.1 under this paragraph for the applicable payment year shall be the final payment and shall
383.2 not be settled to actual costs.

383.3 (c) Effective for services provided on or after July 1, 2003, rates that are based
383.4 on the Medicare outpatient prospective payment system shall be replaced by a budget
383.5 neutral prospective payment system that is derived using medical assistance data. The
383.6 commissioner shall provide a proposal to the 2003 legislature to define and implement
383.7 this provision.

383.8 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,
383.9 before third-party liability and spenddown, made to hospitals for outpatient hospital
383.10 facility services is reduced by .5 percent from the current statutory rate.

383.11 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service
383.12 services provided on or after July 1, 2003, made to hospitals for outpatient hospital
383.13 facility services before third-party liability and spenddown, is reduced five percent from
383.14 the current statutory rates. Facilities defined under section 256.969, subdivision 16, are
383.15 excluded from this paragraph.

House Language UES1458-1

39.30 (a) For outpatient hospital facility fee payments for services rendered on or after
39.31 October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted
39.32 charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those
39.33 services for which there is a federal maximum allowable payment. Effective for services
39.34 rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital
40.1 facility fees and emergency room facility fees shall be increased by eight percent over the
40.2 rates in effect on December 31, 1999, except for those services for which there is a federal
40.3 maximum allowable payment. Services for which there is a federal maximum allowable
40.4 payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum
40.5 allowable payment. Total aggregate payment for outpatient hospital facility fee services
40.6 shall not exceed the Medicare upper limit. If it is determined that a provision of this
40.7 section conflicts with existing or future requirements of the United States government with
40.8 respect to federal financial participation in medical assistance, the federal requirements
40.9 prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to
40.10 avoid reduced federal financial participation resulting from rates that are in excess of
40.11 the Medicare upper limitations.

40.12 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and
40.13 ambulatory surgery hospital facility fee services for critical access hospitals designated
40.14 under section 144.1483, clause (9), shall be paid on a cost-based payment system that is
40.15 based on the cost-finding methods and allowable costs of the Medicare program.

40.34 (g) Effective for services provided on or after July 1, 2015, rates established for
40.35 critical access hospitals under paragraph (b) for the applicable payment year shall be the
40.36 final payment and shall not be settled to actual costs.

40.16 (c) Effective for services provided on or after July 1, 2003, rates that are based
40.17 on the Medicare outpatient prospective payment system shall be replaced by a budget
40.18 neutral prospective payment system that is derived using medical assistance data. The
40.19 commissioner shall provide a proposal to the 2003 legislature to define and implement
40.20 this provision.

40.21 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,
40.22 before third-party liability and spenddown, made to hospitals for outpatient hospital
40.23 facility services is reduced by .5 percent from the current statutory rate.

40.24 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service
40.25 services provided on or after July 1, 2003, made to hospitals for outpatient hospital
40.26 facility services before third-party liability and spenddown, is reduced five percent from
40.27 the current statutory rates. Facilities defined under section 256.969, subdivision 16, are
40.28 excluded from this paragraph.

383.16 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
383.17 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
383.18 hospital facility services before third-party liability and spenddown, is reduced three
383.19 percent from the current statutory rates. Mental health services and facilities defined under
383.20 section 256.969, subdivision 16, are excluded from this paragraph.

40.29 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
40.30 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
40.31 hospital facility services before third-party liability and spenddown, is reduced three
40.32 percent from the current statutory rates. Mental health services and facilities defined under
40.33 section 256.969, subdivision 16, are excluded from this paragraph.

41.1 Sec. 25. Minnesota Statutes 2014, section 256B.76, subdivision 1, is amended to read:

41.2 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on
41.3 or after October 1, 1992, the commissioner shall make payments for physician services
41.4 as follows:

41.5 (1) payment for level one Centers for Medicare and Medicaid Services' common
41.6 procedural coding system codes titled "office and other outpatient services," "preventive
41.7 medicine new and established patient," "delivery, antepartum, and postpartum care,"
41.8 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
41.9 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
41.10 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
41.11 30, 1992. If the rate on any procedure code within these categories is different than the
41.12 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
41.13 then the larger rate shall be paid;

41.14 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
41.15 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

41.16 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
41.17 percentile of 1989, less the percent in aggregate necessary to equal the above increases
41.18 except that payment rates for home health agency services shall be the rates in effect
41.19 on September 30, 1992.

41.20 (b) Effective for services rendered on or after January 1, 2000, payment rates for
41.21 physician and professional services shall be increased by three percent over the rates
41.22 in effect on December 31, 1999, except for home health agency and family planning
41.23 agency services. The increases in this paragraph shall be implemented January 1, 2000,
41.24 for managed care.

41.25 (c) Effective for services rendered on or after July 1, 2009, payment rates for
41.26 physician and professional services shall be reduced by five percent, except that for the
41.27 period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent
41.28 for the medical assistance and general assistance medical care programs, over the rates in
41.29 effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply
41.30 to office or other outpatient visits, preventive medicine visits and family planning visits
41.31 billed by physicians, advanced practice nurses, or physician assistants in a family planning
41.32 agency or in one of the following primary care practices: general practice, general internal
41.33 medicine, general pediatrics, general geriatrics, and family medicine. This reduction
41.34 and the reductions in paragraph (d) do not apply to federally qualified health centers,
41.35 rural health centers, and Indian health services. Effective October 1, 2009, payments
42.1 made to managed care plans and county-based purchasing plans under sections 256B.69,
42.2 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

42.3 (d) Effective for services rendered on or after July 1, 2010, payment rates for
42.4 physician and professional services shall be reduced an additional seven percent over
42.5 the five percent reduction in rates described in paragraph (c). This additional reduction
42.6 does not apply to physical therapy services, occupational therapy services, and speech
42.7 pathology and related services provided on or after July 1, 2010. This additional reduction
42.8 does not apply to physician services billed by a psychiatrist or an advanced practice nurse
42.9 with a specialty in mental health. Effective October 1, 2010, payments made to managed
42.10 care plans and county-based purchasing plans under sections 256B.69, 256B.692, and
42.11 256L.12 shall reflect the payment reduction described in this paragraph.

42.12 (e) Effective for services rendered on or after September 1, 2011, through June 30,
42.13 2013, payment rates for physician and professional services shall be reduced three percent
42.14 from the rates in effect on August 31, 2011. This reduction does not apply to physical
42.15 therapy services, occupational therapy services, and speech pathology and related services.

42.16 (f) Effective for services rendered on or after September 1, 2014, payment rates for
42.17 physician and professional services, including physical therapy, occupational therapy,
42.18 speech pathology, and mental health services shall be increased by five percent from the
42.19 rates in effect on August 31, 2014. In calculating this rate increase, the commissioner
42.20 shall not include in the base rate for August 31, 2014, the rate increase provided under
42.21 section 256B.76, subdivision 7. This increase does not apply to federally qualified health
42.22 centers, rural health centers, and Indian health services. Payments made to managed
42.23 care plans and county-based purchasing plans shall not be adjusted to reflect payments
42.24 under this paragraph.

42.25 (g) Effective for services rendered on or after July 1, 2015, payment rates for
42.26 physical therapy, occupational therapy, and speech pathology and related services provided
42.27 by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph
42.28 (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015.
42.29 Payments made to managed care plans and county-based purchasing plans shall not be
42.30 adjusted to reflect payments under this paragraph.

Senate Language S1458-2

383.21 Sec. 41. Minnesota Statutes 2014, section 256B.76, subdivision 2, is amended to read:

383.22 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after
383.23 October 1, 1992, the commissioner shall make payments for dental services as follows:

383.24 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25
383.25 percent above the rate in effect on June 30, 1992; and

383.26 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th
383.27 percentile of 1989, less the percent in aggregate necessary to equal the above increases.

383.28 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
383.29 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

383.30 (c) Effective for services rendered on or after January 1, 2000, payment rates for
383.31 dental services shall be increased by three percent over the rates in effect on December
383.32 31, 1999.

383.33 (d) Effective for services provided on or after January 1, 2002, payment for
383.34 diagnostic examinations and dental x-rays provided to children under age 21 shall be the
383.35 lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

384.1 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1,
384.2 2000, for managed care.

384.3 (f) Effective for dental services rendered on or after October 1, 2010, by a
384.4 state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based
384.5 on the Medicare principles of reimbursement. This payment shall be effective for services
384.6 rendered on or after January 1, 2011, to recipients enrolled in managed care plans or
384.7 county-based purchasing plans.

384.8 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics
384.9 in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal
384.10 year, a supplemental state payment equal to the difference between the total payments
384.11 in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated
384.12 services for the operation of the dental clinics.

384.13 ~~(h) If the cost-based payment system for state-operated dental clinics described in~~
384.14 ~~paragraph (f) does not receive federal approval, then state-operated dental clinics shall be~~
384.15 ~~designated as critical access dental providers under subdivision 4, paragraph (b), and shall~~
384.16 ~~receive the critical access dental reimbursement rate as described under subdivision 4,~~
384.17 ~~paragraph (a).~~

384.18 ~~(i)~~ (h) Effective for services rendered on or after September 1, 2011, through June
384.19 30, 2013, payment rates for dental services shall be reduced by three percent. This
384.20 reduction does not apply to state-operated dental clinics in paragraph (f).

House Language UES1458-1

42.31 Sec. 26. Minnesota Statutes 2014, section 256B.76, subdivision 2, is amended to read:

42.32 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after
42.33 October 1, 1992, the commissioner shall make payments for dental services as follows:

42.34 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25
42.35 percent above the rate in effect on June 30, 1992; and

43.1 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th
43.2 percentile of 1989, less the percent in aggregate necessary to equal the above increases.

43.3 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
43.4 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

43.5 (c) Effective for services rendered on or after January 1, 2000, payment rates for
43.6 dental services shall be increased by three percent over the rates in effect on December
43.7 31, 1999.

43.8 (d) Effective for services provided on or after January 1, 2002, payment for
43.9 diagnostic examinations and dental x-rays provided to children under age 21 shall be the
43.10 lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

43.11 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1,
43.12 2000, for managed care.

43.13 (f) Effective for dental services rendered on or after October 1, 2010, by a
43.14 state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based
43.15 on the Medicare principles of reimbursement. This payment shall be effective for services
43.16 rendered on or after January 1, 2011, to recipients enrolled in managed care plans or
43.17 county-based purchasing plans.

43.18 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics
43.19 in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal
43.20 year, a supplemental state payment equal to the difference between the total payments
43.21 in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated
43.22 services for the operation of the dental clinics.

43.23 (h) If the cost-based payment system for state-operated dental clinics described in
43.24 paragraph (f) does not receive federal approval, then state-operated dental clinics shall be
43.25 designated as critical access dental providers under subdivision 4, paragraph (b), and shall
43.26 receive the critical access dental reimbursement rate as described under subdivision 4,
43.27 paragraph (a).

43.28 (i) Effective for services rendered on or after September 1, 2011, through June 30,
43.29 2013, payment rates for dental services shall be reduced by three percent. This reduction
43.30 does not apply to state-operated dental clinics in paragraph (f).

384.21 ~~(j)~~ (i) Effective for services rendered on or after January 1, 2014, payment rates for
384.22 dental services shall be increased by five percent from the rates in effect on December
384.23 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f),
384.24 federally qualified health centers, rural health centers, and Indian health services. Effective
384.25 January 1, 2014, payments made to managed care plans and county-based purchasing
384.26 plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase
384.27 described in this paragraph.

384.28 (j) Effective for services rendered on or after July 1, 2015, payment rates for dental
384.29 services shall be set to the percentage of 2012 fee-for-service submitted charges that
384.30 results in a 24 percent increase in the aggregate payment for dental services from the rates
384.31 in effect on June 30, 2015. Effective January 1, 2016, payments made to managed care
384.32 plans and county-based purchasing plans shall reflect the payment increase described in
384.33 this paragraph.

384.34 Sec. 42. Minnesota Statutes 2014, section 256B.76, subdivision 4, is amended to read:

385.1 Subd. 4. **Critical access dental providers.** (a) ~~Effective for dental services~~
385.2 ~~rendered on or after January 1, 2002, the commissioner shall increase reimbursements~~
385.3 ~~to dentists and dental clinics deemed by the commissioner to be critical access dental~~
385.4 ~~providers. For dental services rendered on or after July 1, 2007, the commissioner shall~~
385.5 ~~increase reimbursement by 35 percent above the reimbursement rate that would otherwise~~
385.6 ~~be paid to the critical access dental provider. The commissioner shall pay the managed~~
385.7 ~~care plans and county-based purchasing plans in amounts sufficient to reflect increased~~
385.8 ~~reimbursements to critical access dental providers as approved by the commissioner.~~
385.9 Effective July 1, 2015, the commissioner shall administer an incentive program that makes
385.10 payments to dental clinics that meet the following eligibility criteria:

385.11 (1) nonspecialty dental clinics must meet or exceed the annual median ratio of
385.12 restorative to preventive dental services calculated based on the median ratio of all
385.13 nonspecialty dental clinics serving public health care program enrollees; and

385.14 (2) specialty dental clinics must have provided services to a fee-for-service or
385.15 managed care enrollee during the prior year, and must meet or exceed the annual median
385.16 of dental providers for that dental specialty serving public health care program enrollees.

385.17 (b) ~~The commissioner shall designate the following dentists and dental clinics as~~
385.18 ~~critical access dental providers:~~

385.19 ~~(1) nonprofit community clinics that:~~

385.20 ~~(i) have nonprofit status in accordance with chapter 317A;~~

385.21 ~~(ii) have tax exempt status in accordance with the Internal Revenue Code, section~~
385.22 ~~501(c)(3);~~

385.23 ~~(iii) are established to provide oral health services to patients who are low income,~~
385.24 ~~uninsured, have special needs, and are underserved;~~

43.31 (j) Effective for services rendered on or after January 1, 2014, payment rates for
43.32 dental services shall be increased by five percent from the rates in effect on December
43.33 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f),
43.34 federally qualified health centers, rural health centers, and Indian health services. Effective
43.35 January 1, 2014, payments made to managed care plans and county-based purchasing
44.1 plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase
44.2 described in this paragraph.

44.3 (k) Effective for services rendered on or after July 1, 2015, payment rates for dental
44.4 services shall be increased by five percent from the rates in effect on June 30, 2015. This
44.5 increase does not apply to state-operated dental clinics in paragraph (f), federally qualified
44.6 health centers, rural health centers, and Indian health services. Effective January 1, 2016,
44.7 payments to managed care plans and county-based purchasing plans under sections
44.8 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

385.25 ~~(iv) have professional staff familiar with the cultural background of the clinic's~~
385.26 ~~patients;~~

385.27 ~~(v) charge for services on a sliding fee scale designed to provide assistance to~~
385.28 ~~low-income patients based on current poverty income guidelines and family size;~~

385.29 ~~(vi) do not restrict access or services because of a patient's financial limitations~~
385.30 ~~or public assistance status; and~~

385.31 ~~(vii) have free care available as needed;~~

385.32 ~~(2) federally qualified health centers, rural health clinics, and public health clinics;~~

385.33 ~~(3) city or county owned and operated hospital-based dental clinics;~~

385.34 ~~(4) a dental clinic or dental group owned and operated by a nonprofit corporation in~~
385.35 ~~accordance with chapter 317A with more than 10,000 patient encounters per year with~~
385.36 ~~patients who are uninsured or covered by medical assistance or MinnesotaCare;~~

386.1 ~~(5) a dental clinic owned and operated by the University of Minnesota or the~~
386.2 ~~Minnesota State Colleges and Universities system; and~~

386.3 ~~(6) private practicing dentists if:~~

386.4 ~~(i) the dentist's office is located within a health professional shortage area as defined~~
386.5 ~~under Code of Federal Regulations, title 42, part 5, and United States Code, title 42,~~
386.6 ~~section 254E;~~

386.7 ~~(ii) more than 50 percent of the dentist's patient encounters per year are with patients~~
386.8 ~~who are uninsured or covered by medical assistance or MinnesotaCare;~~

386.9 ~~(iii) the dentist does not restrict access or services because of a patient's financial~~
386.10 ~~limitations or public assistance status; and~~

386.11 ~~(iv) the level of service provided by the dentist is critical to maintaining adequate~~
386.12 ~~levels of patient access within the service area in which the dentist operates.~~

386.13 ~~(c) A designated critical access clinic shall receive the reimbursement rate specified~~
386.14 ~~in paragraph (a) for dental services provided off site at a private dental office if the~~
386.15 ~~following requirements are met:~~

386.16 ~~(1) the designated critical access dental clinic is located within a health professional~~
386.17 ~~shortage area as defined under Code of Federal Regulations, title 42, part 5, and United~~
386.18 ~~States Code, title 42, section 254E, and is located outside the seven-county metropolitan~~
386.19 ~~area;~~

386.20 ~~(2) the designated critical access dental clinic is not able to provide the service~~
386.21 ~~and refers the patient to the off-site dentist;~~

386.22 ~~(3) the service, if provided at the critical access dental clinic, would be reimbursed~~
386.23 ~~at the critical access reimbursement rate;~~

386.24 ~~(4) the dentist and allied dental professionals providing the services off site are~~
386.25 ~~licensed and in good standing under chapter 150A;~~

386.26 ~~(5) the dentist providing the services is enrolled as a medical assistance provider;~~

386.27 ~~(6) the critical access dental clinic submits the claim for services provided off site~~
386.28 ~~and receives the payment for the services; and~~

386.29 ~~(7) the critical access dental clinic maintains dental records for each claim submitted~~
386.30 ~~under this paragraph, including the name of the dentist, the off-site location, and the license~~
386.31 ~~number of the dentist and allied dental professionals providing the services.~~ Eighty percent
386.32 of the total payments made under this subdivision shall be paid to nonspecialty dental
386.33 clinics and 20 percent of the total payments paid shall be paid to specialty dental clinics.

386.34 (c) For fiscal year 2016, the total payments under paragraph (a) shall not exceed the
386.35 total amount paid under the critical access dental program in fiscal year 2015. For fiscal
386.36 year 2017 and each fiscal year thereafter, total payments under paragraph (a) shall be
387.1 adjusted annually based on the value of the dental services component of the medical care
387.2 services expenditure category of the Consumer Price Index for all Urban Consumers
387.3 (CPI-U): U.S. city average from the previous year.

387.4 (d) Payments under paragraph (a) shall be made proportionate to the dental clinic's
387.5 share of enrollees served in both managed care and fee-for-service.

387.6 (e) Payments under paragraph (a) shall be calculated based on the prior fiscal year
387.7 claims submitted and be prorated based on the number of months the dental clinic was
387.8 enrolled in any fee-for-service or managed care program. Payments to dental clinics under
387.9 this subdivision shall be made no later than April 1 of the year following the fiscal year
387.10 for which payments are owed beginning fiscal year 2016.

387.11 (f) To be eligible for payments under this subdivision, a dental clinic must provide
387.12 dental services to medical assistance and MinnesotaCare enrollees.

387.13 (g) No payments under this subdivision shall be made to dental clinics that receive
387.14 a cost-based rate, including, but not limited to, federally qualified health centers and
387.15 state-operated dental clinics.

387.16 Sec. 43. Minnesota Statutes 2014, section 256B.76, subdivision 7, is amended to read:

387.17 Subd. 7. **Payment for certain primary care services and immunization**
387.18 **administration.** (a) Payment for certain primary care services and immunization
387.19 administration services rendered on or after January 1, 2013, through December 31, 2014,
387.20 shall be made in accordance with section 1902(a)(13) of the Social Security Act.

387.21 (b) Effective for primary care services provided on or after July 1, 2015, payment
387.22 rates shall be increased by one percent over the rates in effect on June 30, 2015. Effective
387.23 January 1, 2016, payments made to managed care plans and county-based purchasing
387.24 plans shall reflect the payment increase described in this paragraph.

387.25 (c) Effective for services provided on or after November 1, 2017, payment rates
387.26 shall be increased 0.25 percent over the rates in effect October 31, 2017. Effective January
387.27 1, 2018, payments made to managed care plans and county-based purchasing plans shall
387.28 reflect the payment increase described in this paragraph.

387.29 (d) For purposes of paragraphs (b) and (c), primary care services shall include
387.30 preventive medicine visits or family planning visits when billed by a physician, advanced
387.31 registered nurse practitioner, or physician assistant practicing in a family planning agency,
387.32 general internal medicine practice, general pediatric practice, general geriatric practice, or
387.33 family medicine practice.

44.9 Sec. 27. Minnesota Statutes 2014, section 256B.762, is amended to read:
44.10 **256B.762 REIMBURSEMENT FOR HEALTH CARE SERVICES.**

44.11 (a) Effective for services provided on or after October 1, 2005, payment rates
44.12 for the following services shall be increased by five percent over the rates in effect on
44.13 September 30, 2005, when these services are provided as home health services under
44.14 section 256B.0625, subdivision 6a:

44.15 (1) skilled nursing visit;

44.16 (2) physical therapy visit;

44.17 (3) occupational therapy visit;

44.18 (4) speech therapy visit; and

44.19 (5) home health aide visit.

44.20 (b) Effective for services provided on or after July 1, 2015, payment rates for
44.21 managed care and fee-for-service visits for the following services shall be increased by
44.22 ten percent over the rates in effect on June 30, 2015, when these services are provided as
44.23 home health services under section 256B.0625, subdivision 6a:

44.24 (1) physical therapy;

44.25 (2) occupational therapy; and

44.26 (3) speech therapy.

44.27 The commissioner shall adjust managed care and county-based purchasing plan capitation
44.28 rates to reflect the payment rates under this paragraph.

44.29 Sec. 28. Minnesota Statutes 2014, section 256B.766, is amended to read:
44.30 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

44.31 (a) Effective for services provided on or after July 1, 2009, total payments for basic
44.32 care services, shall be reduced by three percent, except that for the period July 1, 2009,
44.33 through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical
45.1 assistance and general assistance medical care programs, prior to third-party liability and
45.2 spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical
45.3 therapy services, occupational therapy services, and speech-language pathology and
45.4 related services as basic care services. The reduction in this paragraph shall apply to
45.5 physical therapy services, occupational therapy services, and speech-language pathology
45.6 and related services provided on or after July 1, 2010.

45.7 (b) Payments made to managed care plans and county-based purchasing plans shall
45.8 be reduced for services provided on or after October 1, 2009, to reflect the reduction
45.9 effective July 1, 2009, and payments made to the plans shall be reduced effective October
45.10 1, 2010, to reflect the reduction effective July 1, 2010.

45.11 (c) Effective for services provided on or after September 1, 2011, through June 30,
45.12 2013, total payments for outpatient hospital facility fees shall be reduced by five percent
45.13 from the rates in effect on August 31, 2011.

45.14 (d) Effective for services provided on or after September 1, 2011, through June
45.15 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies
45.16 and durable medical equipment not subject to a volume purchase contract, prosthetics
45.17 and orthotics, renal dialysis services, laboratory services, public health nursing services,
45.18 physical therapy services, occupational therapy services, speech therapy services,
45.19 eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume
45.20 purchase contract, and anesthesia services shall be reduced by three percent from the
45.21 rates in effect on August 31, 2011.

45.22 (e) Effective for services provided on or after September 1, 2014, payments
45.23 for ambulatory surgery centers facility fees, hospice services, renal dialysis services,
45.24 laboratory services, public health nursing services, eyeglasses not subject to a volume
45.25 purchase contract, and hearing aids not subject to a volume purchase contract shall be
45.26 increased by three percent and payments for outpatient hospital facility fees shall be
45.27 increased by three percent. Payments made to managed care plans and county-based
45.28 purchasing plans shall not be adjusted to reflect payments under this paragraph.

45.29 (f) Payments for medical supplies and durable medical equipment not subject to a
45.30 volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014,
45.31 through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies
45.32 and durable medical equipment not subject to a volume purchase contract, and prosthetics
45.33 and orthotics, provided on or after July 1, 2015, shall be increased by three percent from
45.34 the rates ~~in effect on June 30, 2014~~ as determined under paragraph (i).

45.35 (g) Effective for services provided on or after July 1, 2015, payments for outpatient
45.36 hospital facility fees, medical supplies and durable medical equipment not subject to a
46.1 volume purchase contract, prosthetics and orthotics, and laboratory services to a hospital
46.2 meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4),
46.3 shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made
46.4 to managed care plans and county-based purchasing plans shall not be adjusted to reflect
46.5 payments under this paragraph.

46.6 (h) This section does not apply to physician and professional services, inpatient
46.7 hospital services, family planning services, mental health services, dental services,
46.8 prescription drugs, medical transportation, federally qualified health centers, rural health
46.9 centers, Indian health services, and Medicare cost-sharing.

46.10 (i) Effective July 1, 2015, the medical assistance payment rate for durable medical
46.11 equipment, prosthetics, orthotics, or supplies shall be restored to the January 1, 2008,
46.12 medical assistance fee schedule, updated to include subsequent rate increases in the
46.13 Medicare and medical assistance fee schedules, and including individually priced
46.14 items for the following categories: enteral nutrition and supplies, customized and other
46.15 specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical
46.16 equipment repair and service. This paragraph does not apply to medical supplies and
46.17 durable medical equipment subject to a volume purchase contract, products subject to the
46.18 preferred diabetic testing supply program, and items provided to dually eligible recipients
46.19 when Medicare is the primary payer for the item.

388.1 Sec. 44. Minnesota Statutes 2014, section 256B.767, is amended to read:
388.2 **256B.767 MEDICARE PAYMENT LIMIT.**

388.3 (a) Effective for services rendered on or after July 1, 2010, fee-for-service payment
388.4 rates for physician and professional services under section 256B.76, subdivision 1, and
388.5 basic care services subject to the rate reduction specified in section 256B.766, shall not
388.6 exceed the Medicare payment rate for the applicable service, as adjusted for any changes
388.7 in Medicare payment rates after July 1, 2010. The commissioner shall implement this
388.8 section after any other rate adjustment that is effective July 1, 2010, and shall reduce rates
388.9 under this section by first reducing or eliminating provider rate add-ons.

388.10 (b) This section does not apply to services provided by advanced practice certified
388.11 nurse midwives licensed under chapter 148 or traditional midwives licensed under chapter
388.12 147D. Notwithstanding this exemption, medical assistance fee-for-service payment rates
388.13 for advanced practice certified nurse midwives and licensed traditional midwives shall
388.14 equal and shall not exceed the medical assistance payment rate to physicians for the
388.15 applicable service.

388.16 (c) This section does not apply to mental health services or physician services billed
388.17 by a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

46.20 Sec. 29. Minnesota Statutes 2014, section 256B.767, is amended to read:
46.21 **256B.767 MEDICARE PAYMENT LIMIT.**

46.22 (a) Effective for services rendered on or after July 1, 2010, fee-for-service payment
46.23 rates for physician and professional services under section 256B.76, subdivision 1, and
46.24 basic care services subject to the rate reduction specified in section 256B.766, shall not
46.25 exceed the Medicare payment rate for the applicable service, as adjusted for any changes
46.26 in Medicare payment rates after July 1, 2010. The commissioner shall implement this
46.27 section after any other rate adjustment that is effective July 1, 2010, and shall reduce rates
46.28 under this section by first reducing or eliminating provider rate add-ons.

46.29 (b) This section does not apply to services provided by advanced practice certified
46.30 nurse midwives licensed under chapter 148 or traditional midwives licensed under chapter
46.31 147D. Notwithstanding this exemption, medical assistance fee-for-service payment rates
46.32 for advanced practice certified nurse midwives and licensed traditional midwives shall
46.33 equal and shall not exceed the medical assistance payment rate to physicians for the
46.34 applicable service.

47.1 (c) This section does not apply to mental health services or physician services billed
47.2 by a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

388.18 (d) Effective for durable medical equipment, prosthetics, orthotics, or supplies
388.19 provided on or after July 1, ~~2013, through June 30,~~ 2015, the payment rate for items
388.20 that are subject to the rates established under Medicare's National Competitive Bidding
388.21 Program shall be equal to the rate that applies to the same item when not subject to the
388.22 rate established under Medicare's National Competitive Bidding Program. This paragraph
388.23 does not apply to mail-order diabetic supplies and does not apply to items provided to
388.24 dually eligible recipients when Medicare is the primary payer of the item.

47.3 ~~(d) Effective for durable medical equipment, prosthetics, orthotics, or supplies~~
47.4 ~~provided on or after July 1, 2013, through June 30, 2015, the payment rate for items~~
47.5 ~~that are subject to the rates established under Medicare's National Competitive Bidding~~
47.6 ~~Program shall be equal to the rate that applies to the same item when not subject to the~~
47.7 ~~rate established under Medicare's National Competitive Bidding Program. This paragraph~~
47.8 ~~does not apply to mail-order diabetic supplies and does not apply to items provided to~~
47.9 ~~dually eligible recipients when Medicare is the primary payer of the item.~~

47.10 (d) Effective July 1, 2015, this section shall not apply to durable medical equipment,
47.11 prosthetics, orthotics, or supplies.

47.12 (e) This section does not apply to physical therapy, occupational therapy, speech
47.13 pathology and related services, and basic care services provided by a hospital meeting the
47.14 criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4).

388.25 Sec. 45. **[256B.79] INTEGRATED CARE FOR HIGH-RISK PREGNANT**
388.26 **WOMEN.**

388.27 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms
388.28 have the meanings given them.

388.29 (b) "Adverse outcomes" means maternal opiate addiction, other reportable prenatal
388.30 substance abuse, low birth weight, or preterm birth.

388.31 (c) "Qualified integrated perinatal care collaborative" or "collaborative" means
388.32 a combination of (1) members of community-based organizations that represent
388.33 communities within the identified targeted populations, and (2) local or tribally based
388.34 service entities, including health care, public health, social services, mental health,
388.35 chemical dependency treatment, and community-based providers, determined by the
389.1 commissioner to meet the criteria for the provision of integrated care and enhanced
389.2 services for enrollees within targeted populations.

389.3 (d) "Targeted populations" means pregnant medical assistance enrollees residing
389.4 in geographic areas identified by the commissioner as being at above-average risk for
389.5 adverse outcomes.

389.6 Subd. 2. **Pilot program established.** The commissioner shall implement a pilot
389.7 program to improve birth outcomes and strengthen early parental resilience for pregnant
389.8 women who are medical assistance enrollees, are at significantly elevated risk for adverse
389.9 outcomes of pregnancy, and are in targeted populations. The program must promote the
389.10 provision of integrated care and enhanced services to these pregnant women, including
389.11 postpartum coordination to ensure ongoing continuity of care, by qualified integrated
389.12 perinatal care collaboratives.

389.13 Subd. 3. **Grant awards.** The commissioner shall award grants to qualifying
389.14 applicants to support interdisciplinary, integrated perinatal care. Grants must be awarded
389.15 beginning July 1, 2016. Grant funds must be distributed through a request for proposals
389.16 process to a designated lead agency within an entity that has been determined to be a
389.17 qualified integrated perinatal care collaborative or within an entity in the process of
389.18 meeting the qualifications to become a qualified integrated perinatal care collaborative.
389.19 Grant awards must be used to support interdisciplinary, team-based needs assessments,
389.20 planning, and implementation of integrated care and enhanced services for targeted
389.21 populations. In determining grant award amounts, the commissioner shall consider the
389.22 identified health and social risks linked to adverse outcomes and attributed to enrollees
389.23 within the identified targeted population.

389.24 Subd. 4. **Eligibility for grants.** To be eligible for a grant under this section, an
389.25 entity must show that the entity meets or is in the process of meeting qualifications
389.26 established by the commissioner to be a qualified integrated perinatal care collaborative.
389.27 These qualifications must include evidence that the entity has or is in the process of
389.28 developing policies, services, and partnerships to support interdisciplinary, integrated care.
389.29 The policies, services, and partnerships must meet specific criteria and be approved by the
389.30 commissioner. The commissioner shall establish a process to review the collaborative's
389.31 capacity for interdisciplinary, integrated care, to be reviewed at the commissioner's
389.32 discretion. In determining whether the entity meets the qualifications for a qualified
389.33 integrated perinatal care collaborative, the commissioner shall verify and review whether
389.34 the entity's policies, services, and partnerships:

389.35 (1) optimize early identification of drug and alcohol dependency and abuse during
389.36 pregnancy, effectively coordinate referrals and follow-up of identified patients to
390.1 evidence-based or evidence-informed treatment, and integrate perinatal care services with
390.2 behavioral health and substance abuse services;

390.3 (2) enhance access to, and effective use of, needed health care or tribal health care
390.4 services, public health or tribal public health services, social services, mental health
390.5 services, chemical dependency services, or services provided by community-based
390.6 providers by bridging cultural gaps within systems of care and by integrating
390.7 community-based paraprofessionals such as doulas and community health workers as
390.8 routinely available service components;

390.9 (3) encourage patient education about prenatal care, birthing, and postpartum
390.10 care, and document how patient education is provided. Patient education may include
390.11 information on nutrition, reproductive life planning, breastfeeding, and parenting;

390.12 (4) integrate child welfare case planning with substance abuse treatment planning
390.13 and monitoring, as appropriate;

390.14 (5) effectively systematize screening, collaborative care planning, referrals, and
390.15 follow up for behavioral and social risks known to be associated with adverse outcomes
390.16 and known to be prevalent within the targeted populations;

390.17 (6) facilitate ongoing continuity of care to include postpartum coordination and
390.18 referrals for interconception care, continued treatment for substance abuse, identification
390.19 and referrals for maternal depression and other chronic mental health conditions,
390.20 continued medication management for chronic diseases, and appropriate referrals to tribal
390.21 or county-based social services agencies and tribal or county-based public health nursing
390.22 services; and

390.23 (7) implement ongoing quality improvement activities as determined by the
390.24 commissioner, including collection and use of data from qualified providers on metrics
390.25 of quality such as health outcomes and processes of care, and the use of other data that
390.26 has been collected by the commissioner.

390.27 Subd. 5. **Gaps in communication, support, and care.** A collaborative receiving
390.28 a grant under this section must develop means of identifying and reporting gaps in the
390.29 collaborative's communication, administrative support, and direct care that must be
390.30 remedied for the collaborative to effectively provide integrated care and enhanced services
390.31 to targeted populations.

390.32 Subd. 6. **Report.** By January 31, 2019, the commissioner shall report to the chairs
390.33 and ranking minority members of the legislative committees with jurisdiction over health
390.34 and human services policy and finance on the status and progress of the pilot program.
390.35 The report must:

390.36 (1) describe the capacity of collaboratives receiving grants under this section;

391.1 (2) contain aggregate information about enrollees served within targeted populations;

391.2 (3) describe the utilization of enhanced prenatal services;

391.3 (4) for enrollees identified with maternal substance use disorders, describe the
391.4 utilization of substance use treatment and dispositions of any child protection cases;

391.5 (5) contain data on outcomes within targeted populations and compare these
391.6 outcomes to outcomes statewide, using standard categories of race and ethnicity; and

391.7 (6) include recommendations for continuing the program or sustaining improvements
391.8 through other means beyond June 30, 2019.

391.9 Subd. 7. **Expiration.** This section expires June 30, 2019.

391.10 Sec. 46. Minnesota Statutes 2014, section 256L.01, subdivision 3a, is amended to read:

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

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

59.7 Sec. 3. Minnesota Statutes 2014, section 256L.01, subdivision 3a, is amended to read:

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

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

Senate Language S1458-2

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

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

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

391.22 Sec. 47. Minnesota Statutes 2014, section 256L.01, subdivision 5, is amended to read:

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

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

391.27 Sec. 48. Minnesota Statutes 2014, section 256L.03, subdivision 5, is amended to read:

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

391.31 (1) $3 per prescription for adult enrollees;

391.32 (2) $25 for eyeglasses for adult enrollees;

392.1 (3) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
392.2 episode of service which is required because of a recipient's symptoms, diagnosis, or
392.3 established illness, and which is delivered in an ambulatory setting by a physician or
392.4 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
392.5 audiologist, optician, or optometrist;

392.6 (4) $6 for nonemergency visits to a hospital-based emergency room for services
392.7 provided through December 31, 2010, and $3.50 effective January 1, 2011; and

392.8 (5) a family deductible equal to the maximum amount allowed under Code of
392.9 Federal Regulations, title 42, part 447.54. $2.75 per month per family and adjusted
392.10 annually by the percentage increase in the medical care component of the CPI-U for
392.11 the period of September to September of the preceding calendar year, rounded to the
392.12 next-higher five cent increment.

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

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

House Language UES1458-1

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

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

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

59.19 Sec. 4. Minnesota Statutes 2014, section 256L.01, subdivision 5, is amended to read:

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

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

59.24 Sec. 5. Minnesota Statutes 2014, section 256L.03, subdivision 5, is amended to read:

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

59.28 (1) $3 per prescription for adult enrollees;

59.29 (2) $25 for eyeglasses for adult enrollees;

59.30 (3) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
59.31 episode of service which is required because of a recipient's symptoms, diagnosis, or
59.32 established illness, and which is delivered in an ambulatory setting by a physician or
60.1 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
60.2 audiologist, optician, or optometrist;

60.3 (4) $6 for nonemergency visits to a hospital-based emergency room for services
60.4 provided through December 31, 2010, and $3.50 effective January 1, 2011; and

60.5 (5) a family deductible equal to the maximum amount allowed under Code of
60.6 Federal Regulations, title 42, part 447.54. $2.75 per month per family and adjusted
60.7 annually by the percentage increase in the medical care component of the CPI-U for
60.8 the period of September to September of the preceding calendar year, rounded to the
60.9 next-higher five-cent increment.

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

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

Senate Language S1458-2

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

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

392.25 **EFFECTIVE DATE.** The amendment to paragraph (a), clause (5), is effective
392.26 retroactively from January 1, 2014. The amendment to paragraph (b) is effective the
392.27 day following final enactment.

392.28 Sec. 49. Minnesota Statutes 2014, section 256L.04, subdivision 1a, is amended to read:

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

392.32 ~~(b) The commissioner shall not deny eligibility to an otherwise eligible applicant~~
392.33 ~~who has applied for a Social Security number and is awaiting issuance of that Social~~
392.34 ~~Security number.~~

393.1 ~~(c) Newborns enrolled under section 256L.05, subdivision 3, are exempt from the~~
393.2 ~~requirements of this subdivision.~~

393.3 ~~(d) Individuals who refuse to provide a Social Security number because of~~
393.4 ~~well-established religious objections are exempt from the requirements of this subdivision.~~
393.5 ~~The term "well-established religious objections" has the meaning given in Code of Federal~~
393.6 ~~Regulations, title 42, section 435.910.~~

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

393.8 Sec. 50. Minnesota Statutes 2014, section 256L.04, subdivision 1c, is amended to read:

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

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

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

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

60.22 **EFFECTIVE DATE.** The amendment to paragraph (a), clause (5), is effective
60.23 retroactively from January 1, 2014. The amendment to paragraph (b) is effective the
60.24 day following final enactment.

60.25 Sec. 6. Minnesota Statutes 2014, section 256L.04, subdivision 1c, is amended to read:

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

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

Senate Language S1458-2

393.15 Sec. 51. Minnesota Statutes 2014, section 256L.04, subdivision 7b, is amended to read:

393.16 Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the
393.17 income limits under this section ~~each July 1 by the annual update of the federal poverty~~
393.18 ~~guidelines following publication by the United States Department of Health and Human~~
393.19 ~~Services except that the income standards shall not go below those in effect on July 1,~~
393.20 ~~2009~~ annually on January 1 as provided in Code of Federal Regulations, title 26, section
393.21 1.36B-1(h).

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

393.23 Sec. 52. Minnesota Statutes 2014, section 256L.05, is amended by adding a subdivision
393.24 to read:

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

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

394.1 Sec. 53. Minnesota Statutes 2014, section 256L.05, subdivision 3, is amended to read:

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60.32 Sec. 7. Minnesota Statutes 2014, section 256L.04, subdivision 7b, is amended to read:

61.1 Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the
61.2 income limits under this section ~~each July 1 by the annual update of the federal poverty~~
61.3 ~~guidelines following publication by the United States Department of Health and Human~~
61.4 ~~Services except that the income standards shall not go below those in effect on July 1,~~
61.5 ~~2009~~ annually on January 1 as provided in Code of Federal Regulations, title 26, section
61.6 1.36B-1(h).

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

61.8 Sec. 8. Minnesota Statutes 2014, section 256L.04, subdivision 10, is amended to read:

61.9 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited
61.10 to citizens or nationals of the United States and lawfully present noncitizens as defined
61.11 in Code of Federal Regulations, title ~~8~~ 45, section ~~103.12~~ 152.2. Undocumented
61.12 noncitizens are ineligible for MinnesotaCare. For purposes of this subdivision, an
61.13 undocumented noncitizen is an individual who resides in the United States without the
61.14 approval or acquiescence of the United States Citizenship and Immigration Services.
61.15 Families with children who are citizens or nationals of the United States must cooperate in
61.16 obtaining satisfactory documentary evidence of citizenship or nationality according to the
61.17 requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

61.18 (b) Notwithstanding subdivisions 1 and 7, eligible persons include families and
61.19 individuals who are lawfully present and ineligible for medical assistance by reason of
61.20 immigration status and who have incomes equal to or less than 200 percent of federal
61.21 poverty guidelines.

61.22 Sec. 9. Minnesota Statutes 2014, section 256L.05, is amended by adding a subdivision
61.23 to read:

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

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

61.30 Sec. 10. Minnesota Statutes 2014, section 256L.05, subdivision 3, is amended to read:

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

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

394.11 (c) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to
394.12 256L.18 are secondary to a plan of insurance or benefit program under which an eligible
394.13 person may have coverage and the commissioner shall use cost avoidance techniques to
394.14 ensure coordination of any other health coverage for eligible persons. The commissioner
394.15 shall identify eligible persons who may have coverage or benefits under other plans of
394.16 insurance or who become eligible for medical assistance.

394.17 (d) The effective date of coverage for individuals or families who are exempt from
394.18 paying premiums under section 256L.15, subdivision 1, paragraph (c), is the first day of
394.19 the month following the month in which ~~verification of American Indian status is received~~
394.20 ~~or~~ eligibility is approved~~, whichever is later~~.

394.21 Sec. 54. Minnesota Statutes 2014, section 256L.05, subdivision 3a, is amended to read:

394.22 Subd. 3a. **~~Renewal~~ Redetermination of eligibility.** (a) ~~Beginning July 1, 2007,~~ An
394.23 enrollee's eligibility must be ~~renewed every 12 months~~ redetermined on an annual basis.
394.24 ~~The 12-month period begins in the month after the month the application is approved.~~ The
394.25 period of eligibility is the entire calendar year following the year in which eligibility is
394.26 redetermined. Beginning in calendar year 2015, eligibility redeterminations shall occur
394.27 during the open enrollment period for qualified health plans as specified in Code of
394.28 Federal Regulations, title 45, section 155.410.

394.29 (b) Each new period of eligibility must take into account any changes in
394.30 circumstances that impact eligibility and premium amount. ~~An enrollee must provide all~~
394.31 ~~the information needed to redetermine eligibility by the first day of the month that ends~~
394.32 ~~the eligibility period. The premium for the new period of eligibility must be received~~
394.33 Coverage begins as provided in section 256L.06 ~~in order for eligibility to continue~~.

394.34 ~~(c) For children enrolled in MinnesotaCare, the first period of renewal begins the~~
394.35 ~~month the enrollee turns 21 years of age.~~

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

395.2 Sec. 55. Minnesota Statutes 2014, section 256L.05, subdivision 4, is amended to read:

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

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

62.8 (c) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to
62.9 256L.18 are secondary to a plan of insurance or benefit program under which an eligible
62.10 person may have coverage and the commissioner shall use cost avoidance techniques to
62.11 ensure coordination of any other health coverage for eligible persons. The commissioner
62.12 shall identify eligible persons who may have coverage or benefits under other plans of
62.13 insurance or who become eligible for medical assistance.

62.14 (d) The effective date of coverage for individuals or families who are exempt from
62.15 paying premiums under section 256L.15, subdivision 1, paragraph (c), is the first day of
62.16 the month following the month in which ~~verification of American Indian status is received~~
62.17 ~~or~~ eligibility is approved~~, whichever is later~~.

62.18 Sec. 11. Minnesota Statutes 2014, section 256L.05, subdivision 3a, is amended to read:

62.19 Subd. 3a. **~~Renewal~~ Redetermination of eligibility.** (a) ~~Beginning July 1, 2007,~~ An
62.20 enrollee's eligibility must be ~~renewed every 12 months~~ redetermined on an annual basis.
62.21 ~~The 12-month period begins in the month after the month the application is approved.~~ The
62.22 period of eligibility is the entire calendar year following the year in which eligibility is
62.23 redetermined. Beginning in calendar year 2015, eligibility redeterminations shall occur
62.24 during the open enrollment period for qualified health plans as specified in Code of
62.25 Federal Regulations, title 45, section 155.410.

62.26 (b) Each new period of eligibility must take into account any changes in
62.27 circumstances that impact eligibility and premium amount. ~~An enrollee must provide all~~
62.28 ~~the information needed to redetermine eligibility by the first day of the month that ends~~
62.29 ~~the eligibility period. The premium for the new period of eligibility must be received~~
62.30 Coverage begins as provided in section 256L.06 ~~in order for eligibility to continue~~.

62.31 ~~(c) For children enrolled in MinnesotaCare, the first period of renewal begins the~~
62.32 ~~month the enrollee turns 21 years of age.~~

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

62.34 Sec. 12. Minnesota Statutes 2014, section 256L.05, subdivision 4, is amended to read:

Senate Language S1458-2

395.3 Subd. 4. **Application processing.** The commissioner of human services shall
395.4 determine an applicant's eligibility for MinnesotaCare no more than ~~30~~ 45 days from the
395.5 date that the application is received by the Department of Human Services as set forth in
395.6 Code of Federal Regulations, title 42, section 435.912. ~~Beginning January 1, 2000, this~~
395.7 ~~requirement also applies to local county human services agencies that determine eligibility~~
395.8 ~~for MinnesotaCare.~~

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

395.10 Sec. 56. Minnesota Statutes 2014, section 256L.06, subdivision 3, is amended to read:

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

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

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

395.28 (d) Nonpayment of the premium will result in disenrollment from the plan
395.29 effective for the calendar month following the month for which the premium was due.
395.30 Persons disenrolled for nonpayment ~~who pay all past due premiums as well as current~~
395.31 ~~premiums due, including premiums due for the period of disenrollment, within 20 days of~~
395.32 ~~disenrollment, shall be reenrolled retroactively to the first day of disenrollment~~ may not
395.33 reenroll prior to the first day of the month following the payment of an amount equal to
395.34 two months' premiums.

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

396.2 Sec. 57. Minnesota Statutes 2014, section 256L.11, is amended by adding a subdivision
396.3 to read:

House Language UES1458-1

63.1 Subd. 4. **Application processing.** The commissioner of human services shall
63.2 determine an applicant's eligibility for MinnesotaCare no more than ~~30~~ 45 days from the
63.3 date that the application is received by the Department of Human Services as set forth in
63.4 Code of Federal Regulations, title 42, section 435.911. ~~Beginning January 1, 2000, this~~
63.5 ~~requirement also applies to local county human services agencies that determine eligibility~~
63.6 ~~for MinnesotaCare.~~

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

63.8 Sec. 13. Minnesota Statutes 2014, section 256L.06, subdivision 3, is amended to read:

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

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

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

63.26 (d) Nonpayment of the premium will result in disenrollment from the plan
63.27 effective for the calendar month following the month for which the premium was due.
63.28 Persons disenrolled for nonpayment ~~who pay all past due premiums as well as current~~
63.29 ~~premiums due, including premiums due for the period of disenrollment, within 20 days of~~
63.30 ~~disenrollment, shall be reenrolled retroactively to the first day of disenrollment~~ may not
63.31 reenroll prior to the first day of the month following the payment of an amount equal to
63.32 two months' premiums.

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

396.4 Subd. 7a. **Dental providers.** Effective for dental services provided to
396.5 MinnesotaCare enrollees on or after January 1, 2016, the payment rate shall be the rate
396.6 described under section 256B.76, subdivision 2, paragraph (i).

396.7 Sec. 58. Minnesota Statutes 2014, section 256L.121, subdivision 1, is amended to read:

396.8 Subdivision 1. **Competitive process.** The commissioner of human services shall
396.9 establish a competitive process for entering into contracts with participating entities for
396.10 the offering of standard health plans through MinnesotaCare. Coverage through standard
396.11 health plans must be available to enrollees beginning January 1, 2015. Each standard
396.12 health plan must cover the health services listed in and meet the requirements of section
396.13 256L.03. The competitive process must meet the requirements of section 1331 of the
396.14 Affordable Care Act and be designed to ensure enrollee access to high-quality health care
396.15 coverage options. The commissioner, to the extent feasible, shall seek to ensure that
396.16 enrollees have a choice of coverage from more than one participating entity within a
396.17 geographic area. In counties that were part of a county-based purchasing plan on January
396.18 1, 2013, the commissioner shall use the medical assistance competitive procurement
396.19 process under section 256B.69, ~~subdivisions 1 to 32,~~ under which selection of entities is
396.20 based on criteria related to provider network access, coordination of health care with other
396.21 local services, alignment with local public health goals, and other factors.

396.22 Sec. 59. Minnesota Statutes 2014, section 256L.15, subdivision 2, is amended to read:

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

396.28 (b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums
396.29 according to the premium scale specified in paragraph ~~(c) with the exception that children~~
396.30 ~~20 years of age and younger in families with income at or below 200 percent of the federal~~
396.31 ~~poverty guidelines shall pay no premiums~~ (d).

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

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

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

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

64.1 Sec. 14. Minnesota Statutes 2014, section 256L.121, subdivision 1, is amended to read:

64.2 Subdivision 1. **Competitive process.** The commissioner of human services shall
64.3 establish a competitive process for entering into contracts with participating entities for
64.4 the offering of standard health plans through MinnesotaCare. Coverage through standard
64.5 health plans must be available to enrollees beginning January 1, 2015. Each standard
64.6 health plan must cover the health services listed in and meet the requirements of section
64.7 256L.03. The competitive process must meet the requirements of section 1331 of the
64.8 Affordable Care Act and be designed to ensure enrollee access to high-quality health care
64.9 coverage options. The commissioner, to the extent feasible, shall seek to ensure that
64.10 enrollees have a choice of coverage from more than one participating entity within a
64.11 geographic area. In counties that were part of a county-based purchasing plan on January
64.12 1, 2013, the commissioner shall use the medical assistance competitive procurement
64.13 process under section 256B.69, ~~subdivisions 1 to 32,~~ under which selection of entities is
64.14 based on criteria related to provider network access, coordination of health care with other
64.15 local services, alignment with local public health goals, and other factors.

	Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
397.5–397.6			
397.7	~~0%~~ 35%	55%	$4
397.8	55%	80%	$6
397.9	80%	90%	$8
397.10	90%	100%	$10
397.11	100%	110%	$12
397.12	110%	120%	~~$15~~ $14
397.13	120%	130%	~~$18~~ $15
397.14	130%	140%	~~$21~~ $16
397.15	140%	150%	$25
397.16	150%	160%	$29
397.17	160%	170%	$33

397.18 170%	180%	$38
397.19 180%	190%	$43
397.20 190%		$50

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

64.16 Sec. 15. Minnesota Statutes 2014, section 270A.03, subdivision 5, is amended to read:

64.17 Subd. 5. **Debt.** (a) "Debt" means a legal obligation of a natural person to pay a fixed 64.18 and certain amount of money, which equals or exceeds $25 and which is due and payable 64.19 to a claimant agency. The term includes criminal fines imposed under section 609.10 or 64.20 609.125, fines imposed for petty misdemeanors as defined in section 609.02, subdivision 64.21 4a, and restitution. A debt may arise under a contractual or statutory obligation, a court 64.22 order, or other legal obligation, but need not have been reduced to judgment.

64.23 A debt includes any legal obligation of a current recipient of assistance which is 64.24 based on overpayment of an assistance grant where that payment is based on a client 64.25 waiver or an administrative or judicial finding of an intentional program violation; 64.26 or where the debt is owed to a program wherein the debtor is not a client at the time 64.27 notification is provided to initiate recovery under this chapter and the debtor is not a 64.28 current recipient of food support, transitional child care, or transitional medical assistance.

64.29 (b) A debt does not include any legal obligation to pay a claimant agency for medical 64.30 care, including hospitalization if the income of the debtor at the time when the medical 64.31 care was rendered does not exceed the following amount:

64.32 (1) for an unmarried debtor, an income of $8,800 or less;

64.33 (2) for a debtor with one dependent, an income of $11,270 or less;

64.34 (3) for a debtor with two dependents, an income of $13,330 or less;

64.35 (4) for a debtor with three dependents, an income of $15,120 or less;

65.1 (5) for a debtor with four dependents, an income of $15,950 or less; and

65.2 (6) for a debtor with five or more dependents, an income of $16,630 or less.

65.3 (c) The commissioner shall adjust the income amounts in paragraph (b) by the
65.4 percentage determined pursuant to the provisions of section 1(f) of the Internal Revenue
65.5 Code, except that in section 1(f)(3)(B) the word "1999" shall be substituted for the word
65.6 "1992." For 2001, the commissioner shall then determine the percent change from the 12
65.7 months ending on August 31, 1999, to the 12 months ending on August 31, 2000, and in
65.8 each subsequent year, from the 12 months ending on August 31, 1999, to the 12 months
65.9 ending on August 31 of the year preceding the taxable year. The determination of the
65.10 commissioner pursuant to this subdivision shall not be considered a "rule" and shall not
65.11 be subject to the Administrative Procedure Act contained in chapter 14. The income
65.12 amount as adjusted must be rounded to the nearest $10 amount. If the amount ends in
65.13 $5, the amount is rounded up to the nearest $10 amount.

65.14 (d) Debt also includes an agreement to pay a MinnesotaCare premium, regardless
65.15 of the dollar amount of the premium authorized under Minnesota Statutes 2014, section
65.16 256L.15, subdivision 1a.

65.17 **EFFECTIVE DATE.** This section is effective January 1, 2016.

65.18 Sec. 16. Minnesota Statutes 2014, section 270B.14, subdivision 1, is amended to read:

65.19 Subdivision 1. **Disclosure to commissioner of human services.** (a) On the request
65.20 of the commissioner of human services, the commissioner shall disclose return information
65.21 regarding taxes imposed by chapter 290, and claims for refunds under chapter 290A, to
65.22 the extent provided in paragraph (b) and for the purposes set forth in paragraph (c).

65.23 (b) Data that may be disclosed are limited to data relating to the identity,
65.24 whereabouts, employment, income, and property of a person owing or alleged to be owing
65.25 an obligation of child support.

65.26 (c) The commissioner of human services may request data only for the purposes of
65.27 carrying out the child support enforcement program and to assist in the location of parents
65.28 who have, or appear to have, deserted their children. Data received may be used only
65.29 as set forth in section 256.978.

65.30 (d) The commissioner shall provide the records and information necessary to
65.31 administer the supplemental housing allowance to the commissioner of human services.

65.32 (e) At the request of the commissioner of human services, the commissioner of
65.33 revenue shall electronically match the Social Security numbers and names of participants
65.34 in the telephone assistance plan operated under sections 237.69 to 237.71, with those of
66.1 property tax refund filers, and determine whether each participant's household income is
66.2 within the eligibility standards for the telephone assistance plan.

66.3 (f) The commissioner may provide records and information collected under sections
66.4 295.50 to 295.59 to the commissioner of human services for purposes of the Medicaid
66.5 Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law
66.6 102-234. Upon the written agreement by the United States Department of Health and
66.7 Human Services to maintain the confidentiality of the data, the commissioner may provide
66.8 records and information collected under sections 295.50 to 295.59 to the Centers for
66.9 Medicare and Medicaid Services section of the United States Department of Health and
66.10 Human Services for purposes of meeting federal reporting requirements.

66.11 (g) The commissioner may provide records and information to the commissioner of
66.12 human services as necessary to administer the early refund of refundable tax credits.

66.13 ~~(h) The commissioner may disclose information to the commissioner of human~~
66.14 ~~services necessary to verify income for eligibility and premium payment under the~~
66.15 ~~MinnesotaCare program, under section 256L.05, subdivision 2.~~

66.16 ~~(i)~~ (h) The commissioner may disclose information to the commissioner of human
66.17 services necessary to verify whether applicants or recipients for the Minnesota family
66.18 investment program, general assistance, food support, Minnesota supplemental aid
66.19 program, and child care assistance have claimed refundable tax credits under chapter 290
66.20 and the property tax refund under chapter 290A, and the amounts of the credits.

66.21 ~~(j)~~ (i) The commissioner may disclose information to the commissioner of human
66.22 services necessary to verify income for purposes of calculating parental contribution
66.23 amounts under section 252.27, subdivision 2a.

66.24 **EFFECTIVE DATE.** This section is effective January 1, 2016.

397.22 Sec. 60. Minnesota Statutes 2014, section 297A.70, subdivision 7, is amended to read:

397.23 Subd. 7. **Hospitals, outpatient surgical centers, and critical access dental**
397.24 **providers.** (a) Sales, except for those listed in paragraph (d), to a hospital are exempt,
397.25 if the items purchased are used in providing hospital services. For purposes of this
397.26 subdivision, "hospital" means a hospital organized and operated for charitable purposes
397.27 within the meaning of section 501(c)(3) of the Internal Revenue Code, and licensed under
397.28 chapter 144 or by any other jurisdiction, and "hospital services" are services authorized or
397.29 required to be performed by a "hospital" under chapter 144.

397.30 (b) Sales, except for those listed in paragraph (d), to an outpatient surgical center
397.31 are exempt, if the items purchased are used in providing outpatient surgical services. For
397.32 purposes of this subdivision, "outpatient surgical center" means an outpatient surgical
397.33 center organized and operated for charitable purposes within the meaning of section
397.34 501(c)(3) of the Internal Revenue Code, and licensed under chapter 144 or by any other
397.35 jurisdiction. For the purposes of this subdivision, "outpatient surgical services" means:
397.36 (1) services authorized or required to be performed by an outpatient surgical center under
398.1 chapter 144; and (2) urgent care. For purposes of this subdivision, "urgent care" means
398.2 health services furnished to a person whose medical condition is sufficiently acute to
398.3 require treatment unavailable through, or inappropriate to be provided by, a clinic or
398.4 physician's office, but not so acute as to require treatment in a hospital emergency room.

398.5 (c) Sales, except for those listed in paragraph (d), to a critical access dental provider
398.6 are exempt, if the items purchased are used in providing critical access dental care
398.7 services. For the purposes of this subdivision, "critical access dental provider" means a
398.8 dentist or dental clinic that qualifies under section 256B.76, subdivision 4, ~~paragraph (b) ,~~
398.9 and, in the previous calendar year, had no more than 15 percent of its patients covered by
398.10 private dental insurance.

398.11 (d) This exemption does not apply to the following products and services:

398.12 (1) purchases made by a clinic, physician's office, or any other medical facility not
398.13 operating as a hospital, outpatient surgical center, or critical access dental provider, even
398.14 though the clinic, office, or facility may be owned and operated by a hospital, outpatient
398.15 surgical center, or critical access dental provider;

398.16 (2) sales under section 297A.61, subdivision 3, paragraph (g), clause (2), and
398.17 prepared food, candy, and soft drinks;

398.18 (3) building and construction materials used in constructing buildings or facilities
398.19 that will not be used principally by the hospital, outpatient surgical center, or critical
398.20 access dental provider;

398.21 (4) building, construction, or reconstruction materials purchased by a contractor or a
398.22 subcontractor as a part of a lump-sum contract or similar type of contract with a guaranteed
398.23 maximum price covering both labor and materials for use in the construction, alteration, or
398.24 repair of a hospital, outpatient surgical center, or critical access dental provider; or

398.25 (5) the leasing of a motor vehicle as defined in section 297B.01, subdivision 11.

398.26 (e) A limited liability company also qualifies for exemption under this subdivision if
398.27 (1) it consists of a sole member that would qualify for the exemption, and (2) the items
398.28 purchased qualify for the exemption.

398.29 (f) An entity that contains both a hospital and a nonprofit unit may claim this
398.30 exemption on purchases made for both the hospital and nonprofit unit provided that:

398.31 (1) the nonprofit unit would have qualified for exemption under subdivision 4; and

Senate Language S1458-2			House Language UES1458-1		
398.32 (2) the items purchased would have qualified for the exemption.					
398.33 Sec. 61. Laws 2008, chapter 363, article 18, section 3, subdivision 5, is amended to read:			47.15 Sec. 30. Laws 2008, chapter 363, article 18, section 3, subdivision 5, is amended to read:		
398.34 Subd. 5. **Basic Health Care Grants**			47.16 Subd. 5. **Basic Health Care Grants**		
398.35 (a) **MinnesotaCare Grants**			47.17 (a) **MinnesotaCare Grants**		
399.1 **Health Care Access**	-0-	(770,000)	47.18 **Health Care Access**	-0-	(770,000)
399.2 **Incentive Program and Outreach Grants.** 399.3 Of the appropriation for the Minnesota health 399.4 care outreach program in Laws 2007, chapter 399.5 147, article 19, section 3, subdivision 7, 399.6 paragraph (b):			47.19 **Incentive Program and Outreach Grants.** 47.20 Of the appropriation for the Minnesota health 47.21 care outreach program in Laws 2007, chapter 47.22 147, article 19, section 3, subdivision 7, 47.23 paragraph (b):		
399.7 (1) $400,000 in fiscal year 2009 from the 399.8 general fund and $200,000 in fiscal year 2009 399.9 from the health care access fund are for the 399.10 incentive program under Minnesota Statutes, 399.11 section 256.962, subdivision 5. For the 399.12 biennium beginning July 1, 2009, base level 399.13 funding for this activity shall be $360,000 399.14 from the general fund and $160,000 from the 399.15 health care access fund; and			47.24 (1) $400,000 in fiscal year 2009 from the 47.25 general fund and $200,000 in fiscal year 2009 47.26 from the health care access fund are for the 47.27 incentive program under Minnesota Statutes, 47.28 section 256.962, subdivision 5. For the 47.29 biennium beginning July 1, 2009, base level 47.30 funding for this activity shall be $360,000 47.31 from the general fund and $160,000 from the 47.32 health care access fund; and		
399.16 (2) $100,000 in fiscal year 2009 from the 399.17 general fund and $50,000 in fiscal year 2009 399.18 from the health care access fund are for the 399.19 outreach grants under Minnesota Statutes, 399.20 section 256.962, subdivision 2. For the 399.21 biennium beginning July 1, 2009, base level 399.22 funding for this activity shall be $90,000 399.23 from the general fund and $40,000 from the 399.24 health care access fund.			48.1 (2) $100,000 in fiscal year 2009 from the 48.2 general fund and $50,000 in fiscal year 2009 48.3 from the health care access fund are for the 48.4 outreach grants under Minnesota Statutes, 48.5 section 256.962, subdivision 2. For the 48.6 biennium beginning July 1, 2009, base level 48.7 funding for this activity shall be $90,000 48.8 from the general fund and $40,000 from the 48.9 health care access fund.		
399.25 (b) **MA Basic Health Care Grants - Families** 399.26 **and Children**	-0-	(17,280,000)	48.10 (b) **MA Basic Health Care Grants - Families** 48.11 **and Children**	-0-	(17,280,000)

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399.27 **Third-Party Liability.** (a) During
399.28 fiscal year 2009, the commissioner shall
399.29 employ a contractor paid on a percentage
399.30 basis to improve third-party collections.
399.31 Improvement initiatives may include, but not
399.32 be limited to, efforts to improve postpayment
399.33 collection from nonresponsive claims and
399.34 efforts to uncover third-party payers the
399.35 commissioner has been unable to identify.

400.1 (b) In fiscal year 2009, the first $1,098,000
400.2 of recoveries, after contract payments and
400.3 federal repayments, is appropriated to
400.4 the commissioner for technology-related
400.5 expenses.

400.6 ~~**Administrative Costs.** (a) For contracts~~
400.7 ~~effective on or after January 1, 2009,~~
400.8 ~~the commissioner shall limit aggregate~~
400.9 ~~administrative costs paid to managed care~~
400.10 ~~plans under Minnesota Statutes, section~~
400.11 ~~256B.69, and to county-based purchasing~~
400.12 ~~plans under Minnesota Statutes, section~~
400.13 ~~256B.692, to an overall average of 6.6 percent~~
400.14 ~~of total contract payments under Minnesota~~
400.15 ~~Statutes, sections 256B.69 and 256B.692,~~
400.16 ~~for each calendar year. For purposes of~~
400.17 ~~this paragraph, administrative costs do not~~
400.18 ~~include premium taxes paid under Minnesota~~
400.19 ~~Statutes, section 297I.05, subdivision 5, and~~
400.20 ~~provider surcharges paid under Minnesota~~
400.21 ~~Statutes, section 256.9657, subdivision 3.~~

400.22 ~~(b) Notwithstanding any law to the contrary,~~
400.23 ~~the commissioner may reduce or eliminate~~
400.24 ~~administrative requirements to meet the~~
400.25 ~~administrative target under paragraph (a).~~

400.26 ~~(c) Notwithstanding any contrary provision~~
400.27 ~~of this article, this rider shall not expire.~~

House Language UES1458-1

48.12 **Third-Party Liability.** (a) During
48.13 fiscal year 2009, the commissioner shall
48.14 employ a contractor paid on a percentage
48.15 basis to improve third-party collections.
48.16 Improvement initiatives may include, but not
48.17 be limited to, efforts to improve postpayment
48.18 collection from nonresponsive claims and
48.19 efforts to uncover third-party payers the
48.20 commissioner has been unable to identify.

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48.22 of recoveries, after contract payments and
48.23 federal repayments, is appropriated to
48.24 the commissioner for technology-related
48.25 expenses.

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48.35 ~~Statutes, sections 256B.69 and 256B.692,~~
48.36 ~~for each calendar year. For purposes of~~
49.1 ~~this paragraph, administrative costs do not~~
49.2 ~~include premium taxes paid under Minnesota~~
49.3 ~~Statutes, section 297I.05, subdivision 5, and~~
49.4 ~~provider surcharges paid under Minnesota~~
49.5 ~~Statutes, section 256.9657, subdivision 3.~~

49.6 ~~(b) Notwithstanding any law to the contrary,~~
49.7 ~~the commissioner may reduce or eliminate~~
49.8 ~~administrative requirements to meet the~~
49.9 ~~administrative target under paragraph (a).~~

49.10 ~~(c) Notwithstanding any contrary provision~~
49.11 ~~of this article, this rider shall not expire.~~

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400.28 **Hospital Payment Delay.** Notwithstanding
400.29 Laws 2005, First Special Session chapter 4,
400.30 article 9, section 2, subdivision 6, payments
400.31 from the Medicaid Management Information
400.32 System that would otherwise have been made
400.33 for inpatient hospital services for medical
400.34 assistance enrollees are delayed as follows:
400.35 (1) for fiscal year 2008, June payments must
401.1 be included in the first payments in fiscal
401.2 year 2009; and (2) for fiscal year 2009,
401.3 June payments must be included in the first
401.4 payment of fiscal year 2010. The provisions
401.5 of Minnesota Statutes, section 16A.124,
401.6 do not apply to these delayed payments.
401.7 Notwithstanding any contrary provision in
401.8 this article, this paragraph expires on June
401.9 30, 2010.

401.10 (c) **MA Basic Health Care Grants - Elderly and** 401.11 **Disabled**	(14,028,000)	(9,368,000)

401.12 **Minnesota Disability Health Options Rate**
401.13 **Setting Methodology.** The commissioner
401.14 shall develop and implement a methodology
401.15 for risk adjusting payments for community
401.16 alternatives for disabled individuals (CADI)
401.17 and traumatic brain injury (TBI) home
401.18 and community-based waiver services
401.19 delivered under the Minnesota disability
401.20 health options program (MnDHO) effective
401.21 January 1, 2009. The commissioner shall
401.22 take into account the weighting system used
401.23 to determine county waiver allocations in
401.24 developing the new payment methodology.
401.25 Growth in the number of enrollees receiving
401.26 CADI or TBI waiver payments through
401.27 MnDHO is limited to an increase of 200
401.28 enrollees in each calendar year from January
401.29 2009 through December 2011. If those limits
401.30 are reached, additional members may be
401.31 enrolled in MnDHO for basic care services
401.32 only as defined under Minnesota Statutes,

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49.12 **Hospital Payment Delay.** Notwithstanding
49.13 Laws 2005, First Special Session chapter 4,
49.14 article 9, section 2, subdivision 6, payments
49.15 from the Medicaid Management Information
49.16 System that would otherwise have been made
49.17 for inpatient hospital services for medical
49.18 assistance enrollees are delayed as follows:
49.19 (1) for fiscal year 2008, June payments must
49.20 be included in the first payments in fiscal
49.21 year 2009; and (2) for fiscal year 2009,
49.22 June payments must be included in the first
49.23 payment of fiscal year 2010. The provisions
49.24 of Minnesota Statutes, section 16A.124,
49.25 do not apply to these delayed payments.
49.26 Notwithstanding any contrary provision in
49.27 this article, this paragraph expires on June
49.28 30, 2010.

49.29 (c) **MA Basic Health Care Grants - Elderly and** 49.30 **Disabled**	(14,028,000)	(9,368,000)

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50.3 delivered under the Minnesota disability
50.4 health options program (MnDHO) effective
50.5 January 1, 2009. The commissioner shall
50.6 take into account the weighting system used
50.7 to determine county waiver allocations in
50.8 developing the new payment methodology.
50.9 Growth in the number of enrollees receiving
50.10 CADI or TBI waiver payments through
50.11 MnDHO is limited to an increase of 200
50.12 enrollees in each calendar year from January
50.13 2009 through December 2011. If those limits
50.14 are reached, additional members may be
50.15 enrolled in MnDHO for basic care services
50.16 only as defined under Minnesota Statutes,

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401.33 section 256B.69, subdivision 28, and the
401.34 commissioner may establish a waiting list for
401.35 future access of MnDHO members to those
401.36 waiver services.

402.1 **MA Basic Elderly and Disabled**
402.2 **Adjustments.** For the fiscal year ending June
402.3 30, 2009, the commissioner may adjust the
402.4 rates for each service affected by rate changes
402.5 under this section in such a manner across
402.6 the fiscal year to achieve the necessary cost
402.7 savings and minimize disruption to service
402.8 providers, notwithstanding the requirements
402.9 of Laws 2007, chapter 147, article 7, section
402.10 71.

402.11 (d) **General Assistance Medical Care Grants**	-0-	(6,971,000)
402.12 (e) **Other Health Care Grants**	-0-	(17,000)

402.13 **MinnesotaCare Outreach Grants Special**
402.14 **Revenue Account.** The balance in the
402.15 MinnesotaCare outreach grants special
402.16 revenue account on July 1, 2009, estimated
402.17 to be $900,000, must be transferred to the
402.18 general fund.

402.19 **Grants Reduction.** Effective July 1, 2008,
402.20 base level funding for nonforecast, general
402.21 fund health care grants issued under this
402.22 paragraph shall be reduced by 1.8 percent at
402.23 the allotment level.

402.24 Sec. 62. Laws 2014, chapter 312, article 24, section 45, subdivision 2, is amended to
402.25 read:

402.26 Subd. 2. **Application for and terms of variance.** A new provider may apply to the
402.27 commissioner, on a form supplied by the commissioner for this purpose, for a variance
402.28 from special transportation service operating standards. The commissioner may grant or
402.29 deny the variance application. Variances expire on the earlier of February 1, ~~2016~~ 2017, or
402.30 ~~the date that the commissioner of transportation begins certifying new providers under the~~
402.31 ~~terms of this act and successor legislation~~ one year after the date the variance was issued.
402.32 The commissioner must not grant variances under this subdivision after June 30, 2016.

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50.17 section 256B.69, subdivision 28, and the
50.18 commissioner may establish a waiting list for
50.19 future access of MnDHO members to those
50.20 waiver services.

50.21 **MA Basic Elderly and Disabled**
50.22 **Adjustments.** For the fiscal year ending June
50.23 30, 2009, the commissioner may adjust the
50.24 rates for each service affected by rate changes
50.25 under this section in such a manner across
50.26 the fiscal year to achieve the necessary cost
50.27 savings and minimize disruption to service
50.28 providers, notwithstanding the requirements
50.29 of Laws 2007, chapter 147, article 7, section
50.30 71.

50.31 (d) **General Assistance Medical Care Grants**	-0-	(6,971,000)
50.32 (e) **Other Health Care Grants**	-0-	(17,000)

50.33 **MinnesotaCare Outreach Grants Special**
50.34 **Revenue Account.** The balance in the
50.35 MinnesotaCare outreach grants special
51.1 revenue account on July 1, 2009, estimated
51.2 to be $900,000, must be transferred to the
51.3 general fund.

51.4 **Grants Reduction.** Effective July 1, 2008,
51.5 base level funding for nonforecast, general
51.6 fund health care grants issued under this
51.7 paragraph shall be reduced by 1.8 percent at
51.8 the allotment level.

402.33 **EFFECTIVE DATE.** This section is effective July 1, 2016.

403.1 Sec. 63. **ADVISORY GROUP ON ADMINISTRATIVE EFFICIENCY AND**
403.2 **REGULATORY SIMPLIFICATION.**

403.3 (a) The commissioner of human services, in consultation with the commissioner
403.4 of health shall convene an advisory group on maximizing administrative efficiency
403.5 and regulatory simplification in state public health care programs. The advisory group
403.6 shall develop recommendations for consistent regulatory and licensure requirements,
403.7 guidelines, definitions, and reporting standards, including a common standardized public
403.8 reporting template for health maintenance organizations and county-based purchasing
403.9 plans that participate in state public health care programs. The advisory group shall take
403.10 into consideration relevant reporting standards of the National Association of Insurance
403.11 Commissioners and the Centers for Medicare and Medicaid Services.

403.12 (b) The membership of the advisory group shall be comprised of the following:

403.13 (1) the commissioner of health or designee;

403.14 (2) the commissioner of human services or designee;

403.15 (3) the commissioner of commerce or designee;

403.16 (4) representatives of the health maintenance organizations and county-based
403.17 purchasing plans; and

403.18 (5) representatives of public and private health care experts and consumer
403.19 representatives, including at least one from a nonprofit organization with legal expertise
403.20 representing low-income consumers.

403.21 (c) The commissioner of health shall submit a report of the recommendations of the
403.22 advisory group to the chairs and ranking minority members of the legislative committees
403.23 with jurisdiction over state public health care programs by February 1, 2017.

403.24 (d) The advisory group shall expire the day after submitting the report required
403.25 under paragraph (c).

403.26 Sec. 64. **STATEWIDE OPIOID PRESCRIBING IMPROVEMENT PROGRAM.**

403.27 The commissioner of human services, in collaboration with the commissioner of
403.28 health, shall report to the legislature by December 1, 2015, on recommendations made
403.29 by the opioid prescribing work group under Minnesota Statutes, section 256B.0638,
403.30 subdivision 4, and steps taken by the commissioner of human services to implement the
403.31 opioid prescribing improvement program under Minnesota Statutes, section 256B.0638,
403.32 subdivision 5.

403.33 Sec. 65. **TASK FORCE ON HEALTH CARE FINANCING.**

404.1 Subdivision 1. **Task force.** (a) The governor shall convene a task force on health
404.2 care financing to advise the governor and legislature on strategies that will increase access
404.3 to and improve the quality of health care for Minnesotans. These strategies shall include
404.4 options for sustainable health care financing, coverage, purchasing, and delivery for all
404.5 insurance affordability programs, including MNsure, medical assistance, MinnesotaCare,
404.6 and individuals eligible to purchase coverage with federal advanced premium tax credits
404.7 and cost-sharing subsidies.

404.8 (b) The task force shall consist of:

404.9 (1) seven members appointed by the senate, four members appointed by the majority
404.10 leader of the senate, one of whom must be a legislator; and three members appointed by
404.11 the minority leader of the senate, one of whom must be a legislator;

404.12 (2) seven members of the house of representatives, four members appointed by the
404.13 speaker of the house, one of whom must be a legislator; and three members appointed by
404.14 the minority leader of the house of representatives, one of whom must be a legislator;

404.15 (3) 11 members appointed by the governor, including public and private health care
404.16 experts and consumer representatives. The consumer representatives must include one
404.17 member from a nonprofit organization with legal expertise representing low-income
404.18 consumers, at least one member from a broad-based nonprofit consumer advocacy
404.19 organization, and at least one member from an organization representing consumers of
404.20 color; and

404.21 (4) the commissioners of MNsure, commerce, and health, or their designees.

404.22 (c) The commissioner of human services and a member of the task force voted
404.23 by the task force shall serve as cochairs of the task force. The commissioner of human
404.24 services shall convene the first meeting and the members shall vote on the cochair position
404.25 at the first meeting.

404.26 Subd. 2. **Duties.** (a) The task force shall consider opportunities, including
404.27 alternatives to MNsure, options under section 1332 of the Patient Protection and Affordable
404.28 Care Act, and options under a section 1115 waiver of the Social Security Act, including:

404.29 (1) options for providing and financing seamless coverage for persons
404.30 otherwise eligible for insurance affordability programs, including medical assistance,
404.31 MinnesotaCare, and advanced premium tax credits used to purchase commercial
404.32 insurance. This includes, but is not limited to: alignment of eligibility and enrollment
404.33 requirements; smoothing consumer cost-sharing across programs; alignment and
404.34 alternatives to benefit sets; alternatives to the individual mandate; the employer mandate
404.35 and penalties; advanced premium tax credits; and qualified health plans;

405.1 (2) options for transforming health care purchasing and delivery, including, but not
405.2 limited to: expansion of value-based direct contracting with providers and other entities
405.3 to reward improved health outcomes and reduced costs, including selective contracting;
405.4 contracting to provide services to public programs and commercial products; and payment
405.5 models that support and reward coordination of care across the continuum of services
405.6 and programs;

405.7 (3) options for alignment, consolidation, and governance of certain operational
405.8 components, including, but not limited to: MNsure; program eligibility, enrollment, call
405.9 centers, and contracting; and the shared eligibility IT platform; and

405.10 (4) examining the impact of options on the health care workforce and delivery
405.11 system, including, but not limited to, rural and safety net providers, clinics, and hospitals.

405.12 (b) In development of the options in paragraph (a), the task force options and
405.13 recommendations shall include the following goals:

405.14 (1) seamless consumer experience across all programs;

405.15 (2) reducing barriers to accessibility and affordability of coverage;

405.16 (3) improving sustainable financing of health programs, including impact on the
405.17 state budget;

405.18 (4) assessing the impact of options for innovation on their potential to reduce
405.19 health disparities;

405.20 (5) expanding innovative health care purchasing and delivery systems strategies that
405.21 reduce cost and improve health;

405.22 (6) promoting effectively and efficiently aligning program resources and operations;
405.23 and

405.24 (7) increasing transparency and accountability of program operations.

405.25 Subd. 3. **Staff.** (a) The commissioner of human services shall provide staff and
405.26 administrative services for the task force. The commissioner may accept outside resources
405.27 to help support its efforts and shall leverage its existing vendor contracts to provide
405.28 technical expertise to develop options under subdivision 2. The commissioner of human
405.29 services shall receive expedited review and publication of competitive procurements for
405.30 additional vendor support needed to support the task force.

405.31 (b) Technical assistance shall be provided by the Departments of Health, Commerce,
405.32 Human Services, and Management and Budget.

405.33 Subd. 4. **Report.** The commissioner of human services shall submit
405.34 recommendations by January 15, 2016, to the governor and the chairs and ranking
405.35 minority members of the legislative committees with jurisdiction over health, human
405.36 services, and commerce policy and finance.

406.1 Subd. 5. **Expiration.** The task force expires the day after submitting the report
406.2 required under subdivision 4.

406.3 Sec. 66. **HEALTH DISPARITIES PAYMENT ENHANCEMENT.**

406.4 (a) The commissioner of human services shall develop a methodology to pay a
406.5 higher payment rate for health care providers and services that takes into consideration
406.6 the higher cost, complexity, and resources needed to serve patients and populations
406.7 who experience the greatest health disparities in order to achieve the same health and
406.8 quality outcomes that are achieved for other patients and populations. In developing
406.9 the methodology, the commissioner shall take into consideration all existing payment
406.10 methods and rates, including add-on or enhanced rates paid to providers serving high
406.11 concentrations of low-income patients or populations or providing access in underserved
406.12 regions or populations. The new methodology must not result in a net decrease in total
406.13 payment from all sources for those providers who qualify for additional add-on payments
406.14 or enhanced payments, including, but not limited to, critical access dental, community
406.15 clinic add-ons, federally qualified health centers payment rates, and disproportionate share
406.16 payments. The commissioner shall develop the methodology in consultation with affected
406.17 stakeholders, including communities impacted by health disparities, using culturally
406.18 appropriate methods of community engagement. The proposed methodology must include
406.19 recommendations for how the methodology could be incorporated into payment methods
406.20 used in both fee-for-service and managed care plans.

406.21 (b) The commissioner shall submit a report on the analysis and provide options
406.22 for new payment methodologies that incorporate health disparities to the chairs and
406.23 ranking minority members of the legislative committees with jurisdiction over health care
406.24 policy and finance by February 1, 2016. The scope of the report and the development
406.25 work described in paragraph (a) is limited to data currently available to the Department
406.26 of Human Services; analyses of the data for reliability and completeness; analyses of
406.27 how these data relate to health disparities, outcomes, and expenditures; and options for
406.28 incorporating these data or measures into a payment methodology.

51.9 Sec. 31. **REDUCTION IN ADMINISTRATIVE COSTS.**

51.10 The commissioner of human services, when contracting with managed care and
51.11 county-based purchasing plans for the provision of services under Minnesota Statutes,
51.12 sections 256B.69 and 256B.692, for calendar years 2016 and 2017, shall negotiate
51.13 reductions in managed care and county-based purchasing plan administrative costs,
51.14 sufficient to achieve a state medical assistance savings of $100,000,000 for the biennium
51.15 ending June 30, 2017.

51.16 Sec. 32. **ADVISORY GROUP ON ADMINISTRATIVE EXPENSES.**

51.17 Subdivision 1. **Duties.** The commissioner of health shall reconvene the Advisory
51.18 Group on Administrative Expenses, established under Laws 2010, First Special Session
51.19 chapter 1, article 20, section 3, to develop detailed standards and procedures for examining
51.20 the reasonableness of administrative expenses by individual state public programs.
51.21 The advisory group shall develop consistent guidelines, definitions, and reporting
51.22 requirements, including a common standardized public reporting template for health
51.23 maintenance organizations and county-based purchasing plans that participate in state
51.24 public programs. The advisory group shall take into consideration relevant reporting
51.25 standards of the National Association of Insurance Commissioners and the Centers for
51.26 Medicare and Medicaid Services. The advisory group shall expire on January 1, 2016.

51.27 Subd. 2. **Membership.** The advisory group shall be composed of the following
51.28 members, who serve at the pleasure of their appointing authority:

51.29 (1) the commissioner of health or the commissioner's designee;

51.30 (2) the commissioner of human services or the commissioner's designee;

51.31 (3) the commissioner of commerce or the commissioner's designee; and

51.32 (4) representatives of health maintenance organizations and county-based purchasing
51.33 plans appointed by the commissioner of health.

52.1 Sec. 33. **CAPITATION PAYMENT DELAY.**

52.2 (a) The commissioner of human services shall delay $135,000,000 of the medical
52.3 assistance capitation payment to managed care plans and county-based purchasing plans
52.4 due in May 2017 and the payment due in April 2017 for special needs basic care until
52.5 July 1, 2017. The payment shall be made no earlier than July 1, 2017, and no later than
52.6 July 31, 2017.

52.7 (b) The commissioner of human services shall delay $135,000,000 of the medical
52.8 assistance capitation payment to managed care plans and county-based purchasing plans
52.9 due in the second quarter of calendar year 2019 and the April 2019 payment for special
52.10 needs basic care until July 1, 2019. The payment shall be made no earlier than July 1,
52.11 2019, and no later than July 31, 2019.

52.12 Sec. 34. **HEALTH AND ECONOMIC ASSISTANCE PROGRAM ELIGIBILITY**
52.13 **VERIFICATION AUDIT SERVICES.**

52.14 Subdivision 1. **Request for proposals.** By October 1, 2015, the commissioner of
52.15 human services shall issue a request for proposals for a contract to provide eligibility
52.16 verification audit services for benefits provided through health and economic assistance
52.17 programs. The request for proposals must require that the vendor:

52.18 (1) conduct an eligibility verification audit of all health and economic assistance
52.19 program recipients that includes, but is not limited to, appropriate data matching against
52.20 relevant state and federal databases;

52.21 (2) identify any ineligible recipients in these programs and report those findings
52.22 to the commissioner; and

52.23 (3) identify a process for ongoing eligibility verification of health and economic
52.24 assistance program recipients and applicants, following the conclusion of the eligibility
52.25 verification audit required by this section.

52.26 Subd. 2. **Additional vendor criteria.** The request for proposals must require the
52.27 vendor to provide the following minimum capabilities and experience in performing the
52.28 services described in subdivision 1:

52.29 (1) a rules-based process for making objective eligibility determinations;

52.30 (2) assigned eligibility advocates to assist recipients through the verification process;

52.31 (3) a formal claims and appeals process; and

52.32 (4) experience in the performance of eligibility verification audits.

52.33 Subd. 3. **Contract required.** (a) By January 1, 2016, the commissioner must enter
52.34 into a contract for the services specified in subdivision 1. The contract must:

53.1 (1) incorporate performance-based vendor financing that compensates the vendor
53.2 based on the amount of savings generated by the work performed under the contract;

53.3 (2) require the vendor to reimburse the commissioner and county agencies for all
53.4 reasonable costs incurred in implementing this section, out of savings generated by the
53.5 work performed under the contract;

53.6 (3) require the vendor to comply with enrollee data privacy requirements and to use
53.7 encryption to safeguard enrollee identity; and

53.8 (4) provide penalties for vendor noncompliance.

53.9 (b) The commissioner may renew the contract for up to three additional one-year
53.10 periods. The commissioner may require additional eligibility verification audits, if
53.11 the commissioner or the legislative auditor determines that the MNsure information
53.12 technology system and agency eligibility determination systems cannot effectively verify
53.13 the eligibility of health and economic assistance program recipients.

53.14 Subd. 4. **Health and economic assistance program.** For purposes of this section,
53.15 "health and economic assistance program" means the medical assistance program under
53.16 Minnesota Statutes, chapter 256B, Minnesota family investment and diversionary
53.17 work programs under Minnesota Statutes, chapter 256J, child care assistance programs
53.18 under Minnesota Statutes, chapter 119B, general assistance under Minnesota Statutes,
53.19 sections 256D.01 to 256D.23, alternative care program under Minnesota Statutes, section
53.20 256B.0913, and chemical dependency programs funded under Minnesota Statutes, chapter
53.21 254B.

53.22 Sec. 35. **REQUEST FOR PROPOSALS.**

53.23 (a) The commissioner of human services shall issue a request for proposals
53.24 for a contract to use technologically advanced software and services to improve the
53.25 identification and rejection or elimination of:

53.26 (1) improper Medicaid payments before payment is made to the provider; and

53.27 (2) improper provision of benefits by a health and economic assistance program
53.28 to ineligible individuals.

53.29 (b) The request for proposals must ensure that a system recommended and
53.30 implemented by the contractor will:

53.31 (1) implement a more comprehensive, robust, and technologically advanced
53.32 improper payments and benefits identification program;

53.33 (2) utilize state of the art fraud detection methods and technologies such as predictive
53.34 modeling, link analysis, and anomaly and outlier detection;

53.35 (3) have the ability to identify and report improper claims before the claims are paid;

54.1 (4) have the ability to identify and report the improper provision of benefits under a
54.2 health and economic assistance program;

54.3 (5) include a mechanism so that the system improves its detection capabilities over
54.4 time;

54.5 (6) leverage technology to make the Medicaid claims evaluation process more
54.6 transparent and cost-efficient; and

54.7 (7) result in increased state savings by reducing or eliminating payouts of wrongful
54.8 Medicaid claims and the improper provision of health and economic assistance program
54.9 benefits.

54.10 (c) Based on responses to the request for proposals, the commissioner must enter
54.11 into a contract for the services specified in paragraphs (a) and (b) by October 1, 2015. The
54.12 contract shall incorporate a performance-based vendor financing option whereby the
54.13 vendor shares in the risk of the project's success.

54.14 (d) For purposes of this section, "health and economic assistance program" means
54.15 the medical assistance program under Minnesota Statutes, chapter 256B, Minnesota family
54.16 investment and diversionary work programs under Minnesota Statutes, chapter 256J, child
54.17 care assistance programs under Minnesota Statutes, chapter 119B, general assistance
54.18 under Minnesota Statutes, sections 256D.01 to 256D.23, alternative care program under
54.19 Minnesota Statutes, section 256B.0913, and chemical dependency programs funded under
54.20 Minnesota Statutes, chapter 254B.

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

54.22 Sec. 36. **FEDERAL WAIVER OR APPROVAL.**

54.23 The commissioner of human services shall seek any federal waiver or approval
54.24 necessary to implement the amendments to Minnesota Statutes, section 256B.0644.

66.25 Sec. 17. **REVISOR INSTRUCTION.**

66.26 In Minnesota Statutes and Minnesota Rules, the revisor of statutes shall strike
66.27 references to Minnesota Statutes, chapter 256L, and to statutory sections within that
66.28 chapter, and shall make all necessary grammatical and conforming changes.

66.29 **EFFECTIVE DATE.** This section is effective January 1, 2016.

406.29 Sec. 67. **REPEALER.**

406.30 (a) Minnesota Statutes 2014, sections 256.969, subdivisions 23 and 30; and 256B.69,
406.31 subdivision 32, are repealed and effective July 1, 2015.

406.32 (b) Minnesota Statutes 2014, sections 256L.02, subdivision 3; and 256L.05,
406.33 subdivisions 1b, 1c, 3c, and 5, are repealed and effective the day following final enactment.

407.1 (c) Minnesota Statutes 2014, section 256L.11, subdivision 7, is repealed and
407.2 effective July 1, 2015.

407.3 (d) Minnesota Rules, part 8840.5900, subparts 12 and 14, are repealed and effective
407.4 January 1, 2016.

66.30 Sec. 18. **REPEALER.**

66.31 Subdivision 1. **MinnesotaCare program.** Minnesota Statutes 2014, sections
66.32 256L.01, subdivisions 1, 1a, 1b, 2, 3, 3a, 5, 6, and 7; 256L.02, subdivisions 1, 2, 3, 5, and
66.33 6; 256L.03, subdivisions 1, 1a, 1b, 2, 3, 3a, 3b, 4, 4a, 5, and 6; 256L.04, subdivisions 1,
67.1 1a, 1c, 2, 2a, 7, 7a, 7b, 8, 10, 12, 13, and 14; 256L.05, subdivisions 1, 1a, 1b, 1c, 2, 3, 3a,
67.2 3c, 4, 5, and 6; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3, and 4; 256L.09,
67.3 subdivisions 1, 2, 4, 5, 6, and 7; 256L.10; 256L.11, subdivisions 1, 2, 2a, 3, 4, and 7;
67.4 256L.12; 256L.121; 256L.15, subdivisions 1, 1a, 1b, and 2; 256L.18; 256L.22; 256L.24;
67.5 256L.26; and 256L.28, are repealed.

67.6 Subd. 2. **Conforming repealers.** Minnesota Statutes 2014, sections 13.461,
67.7 subdivision 26; 16A.724, subdivision 3; 62A.046, subdivision 5; and 256.01, subdivision
67.8 35, are repealed.

67.9 **EFFECTIVE DATE.** This section is effective January 1, 2016.