State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 3439

02/17/2026 Authored by Nadeau and Backer
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to human services; modifying eligibility for medical assistance and expedited disability determinations; requiring review of death master file; providing contract requirements for managed care plans; amending Minnesota Statutes 2024, sections 256B.056, subdivisions 1a, 7; 256B.0561, subdivisions 1, 2; 256B.06, subdivision 4; 256B.061; 256B.69, subdivision 5a; Minnesota Statutes 2025 Supplement, section 256.01, subdivision 29a; proposing coding for new law in Minnesota Statutes, chapter 256B.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2025 Supplement, section 256.01, subdivision 29a, is amended to read:

Subd. 29a. **State medical review team; expedited disability determinations.** (a) The commissioner must establish an expedited disability determination process within the state medical review team for applicants in the following high-risk categories:

(1) individuals in a facility who cannot be discharged without home and community-based services or long-term care supports in place;

(2) individuals experiencing life-threatening medical conditions requiring urgent access to treatment or prescription medication;

(3) individuals diagnosed with a condition listed on the Social Security Administration's Compassionate Allowance List; ~~and~~

(4) children under the age of two who have screened positive for a rare disease recognized by national medical registries or evidence-based standards~~.~~<u>; and</u>

<u>(5) individuals enrolled under section 256B.055, subdivision 15, who are at risk of losing eligibility for medical assistance.</u>

(b) Hospitals submitting requests under paragraph (a) must complete an application for medical assistance prior to an expedited request and assist patients with returning required documentation necessary to determine disability.

(c) The commissioner must designate staff within the state medical review team to coordinate expedited requests, communicate with county and tribal agencies, and ensure timely electronic transmission of required documentation, including the use of electronic signature platforms.

(d) For applicants subject to expedited review, medical assistance providers must comply with subdivision 29. If electronic health records are unavailable, requesting providers must coordinate with the state medical review team to obtain the medical records necessary to support the disability determination.

(e) The commissioner must maintain a contract for electronic signature and document transmission services to support expedited determinations.

Sec. 2. Minnesota Statutes 2024, section 256B.056, subdivision 1a, is amended to read:

Subd. 1a. **Income and assets generally.** (a)(1) Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the Supplemental Security Income program shall be used, except as provided in clause (2) and subdivision 3, paragraph (a), clause (6).

(2) State tax credits, rebates, and refunds must not be counted as income. State tax credits, rebates, and refunds must not be counted as assets for a period of 12 months after the month of receipt.

(3) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year. Effective upon federal approval, for children eligible under section 256B.055, subdivision 12, or for home and community-based waiver services whose eligibility for medical assistance is determined without regard to parental income, child support payments, including any payments made by an obligor in satisfaction of or in addition to a temporary or permanent order for child support, and Social Security payments are not counted as income.

(b)(1) The modified adjusted gross income methodology as defined in United States Code, title 42, section 1396a(e)(14), shall be used for eligibility categories based on:

(i) children under age 19 and their parents and relative caretakers as defined in section 256B.055, subdivision 3a;

(ii) children ages 19 to 20 as defined in section 256B.055, subdivision 16;

(iii) pregnant women as defined in section 256B.055, subdivision 6;

(iv) infants as defined in sections 256B.055, subdivision 10, and 256B.057, subdivision 1; and

(v) adults without children as defined in section 256B.055, subdivision 15.

For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

(2) For individuals whose income eligibility is determined using the modified adjusted gross income methodology in clause (1):

(i) the commissioner shall subtract from the individual's modified adjusted gross income an amount equivalent to five percent of the federal poverty guidelines; and

(ii) the individual's current monthly income and household size is used to determine eligibility for the ~~12-month~~ eligibility period. If an individual's income is expected to vary month to month, eligibility is determined based on the income predicted for the ~~12-month~~ eligibility period.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 3. Minnesota Statutes 2024, section 256B.056, subdivision 7, is amended to read:

Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application and for ~~three~~:

(1) one month prior to application for an individual eligible under section 256B.055, subdivision 15, if the individual was eligible in the prior month; and

(2) two months prior to application for all other eligible individuals if the ~~person~~ individual was eligible in those prior months. ~~A redetermination of eligibility~~

(b) For redeterminations of eligibility scheduled to occur on or after January 1, 2027, the redeterminations must occur:

(1) every six months for individuals enrolled under section 256B.055, subdivision 15, except individuals described in United States Code, title 42, section 1396a(xx)(9)(A)(i)(VIII); and

(2) every 12 months for all other recipients.

~~(b)~~ (c) Notwithstanding any other law to the contrary:

(1) a child under 19 years of age who is determined eligible for medical assistance must remain eligible for a period of 12 months;

(2) a child 19 years of age and older but under 21 years of age who is determined eligible for medical assistance must remain eligible for a period of 12 months; and

(3) a child under six years of age who is determined eligible for medical assistance must remain eligible through the month in which the child reaches six years of age.

~~(c)~~ (d) A child's eligibility under paragraph ~~(b)~~ (c) may be terminated earlier if:

(1) the child or the child's representative requests voluntary termination of eligibility;

(2) the child ceases to be a resident of this state;

(3) the child dies;

(4) the child attains the maximum age; or

(5) the agency determines eligibility was erroneously granted at the most recent eligibility determination due to agency error or fraud, abuse, or perjury attributed to the child or the child's representative.

~~(d)~~ (e) For ~~a person~~ an individual eligible for an insurance affordability program as defined in section 256B.02, subdivision 19, who reports a change that makes the ~~person~~ individual eligible for medical assistance, eligibility is available for the month the change was reported and for ~~three~~ one month prior to the month the change was reported for an individual eligible under section 256B.055, subdivision 15, and two months prior to the month the change was reported for all other eligible individuals, if the ~~person~~ individual was eligible in ~~those~~ the prior month or months.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 4. Minnesota Statutes 2024, section 256B.0561, subdivision 1, is amended to read:

Subdivision 1. **Definition.** For the purposes of this section, "periodic data matching" means obtaining updated electronic information about medical assistance and MinnesotaCare recipients on the MNsure information system from federal and state data sources accessible to the MNsure information system and using that data to evaluate continued eligibility between regularly scheduled renewals. Periodic data matching does not include review of the death master file under section 256B.0562.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 5. Minnesota Statutes 2024, section 256B.0561, subdivision 2, is amended to read:

Subd. 2. **Periodic data matching.** (a) The commissioner shall conduct periodic data matching to identify recipients who, based on available electronic data, may not meet eligibility criteria for the public health care program in which the recipient is enrolled. The commissioner shall conduct data matching for medical assistance or MinnesotaCare recipients at least once during a recipient's ~~12-month~~ period of eligibility.

(b) If data matching indicates a recipient may no longer qualify for medical assistance or MinnesotaCare, the commissioner must notify the recipient and allow the recipient no more than 30 days to confirm the information obtained through the periodic data matching or provide a reasonable explanation for the discrepancy to the state or county agency directly responsible for the recipient's case. If a recipient does not respond within the advance notice period or does not respond with information that demonstrates eligibility or provides a reasonable explanation for the discrepancy within the 30-day time period, the commissioner shall terminate the recipient's eligibility in the manner provided for by the laws and regulations governing the health care program for which the recipient has been identified as being ineligible.

(c) The commissioner shall not terminate eligibility for a recipient who is cooperating with the requirements of paragraph (b) and needs additional time to provide information in response to the notification.

(d) A recipient whose eligibility was terminated according to paragraph (b) may be eligible for medical assistance no earlier than the first day of the month in which the recipient provides information that demonstrates the recipient's eligibility.

(e) Any termination of eligibility for benefits under this section may be appealed as provided for in sections 256.045 to 256.0451, and the laws governing the health care programs for which eligibility is terminated.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 6. **[256B.0562] REVIEW OF DEATH MASTER FILE.**

Subdivision 1. **Definition.** For purposes of this section, "death master file" means information about deceased individuals maintained by the Social Security Administration under United States Code, title 42, section 1306c(d), or any successor system.

Subd. 2. **Review of the death master file.** (a) Beginning January 1, 2027, the commissioner must review the death master file at least quarterly to identify any medical assistance recipients who are deceased.

(b) If review of the death master file or any other source indicates that a recipient is deceased, the commissioner must:

(1) terminate the recipient's eligibility for medical assistance in the manner provided for by the laws and regulations governing medical assistance;

(2) notify the recipient and the recipient's representative no later than the date of the termination; and

(3) discontinue any payments to providers under this chapter made on behalf of the recipient as of the date of the termination.

(c) If the commissioner determines that a recipient was misidentified as deceased and erroneously disenrolled from medical assistance based on information obtained from the death master file or any other source, the commissioner must immediately re-enroll the individual in medical assistance retroactive to the date of termination under paragraph (b).

Subd. 3. **Review of other sources.** Nothing in this section prevents the commissioner from reviewing other sources to identify recipients of medical assistance who are deceased, provided the commissioner is in compliance with this section and all other requirements under this chapter related to medical assistance eligibility determination and redetermination.

Sec. 7. Minnesota Statutes 2024, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States as described in this subdivision. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

~~(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;~~

~~(3) granted asylum according to United States Code, title 8, section 1158;~~

~~(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);~~

~~(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);~~

~~(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);~~

~~(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;~~

~~(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or~~

~~(9)~~ (2) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980~~.~~; or

(3) lawfully resides in the United States in accordance with a Compact of Free Association under United States Code, title 8, section 1612(b)(2)(G).

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

~~(d) Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:~~

~~(1) refugees admitted to the United States according to United States Code, title 8, section 1157;~~

~~(2) persons granted asylum according to United States Code, title 8, section 1158;~~

~~(3) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);~~

~~(4) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or~~

~~(5) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.~~

(d) Beginning July 1, 2010, children and pregnant women who are noncitizens described in paragraph (b) or who are lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation as provided by the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

(e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(f) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition.

(g) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment of an emergency medical condition are limited to the following:

(i) services delivered in an emergency room or by an ambulance service licensed under chapter 144E that are directly related to the treatment of an emergency medical condition;

(ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; and

(iii) follow-up services that are directly related to the original service provided to treat the emergency medical condition and are covered by the global payment made to the provider.

(2) Services for the treatment of emergency medical conditions do not include:

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ transplants, stem cell transplants, and related care;

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

(viii) rehabilitation services;

(ix) physical, occupational, or speech therapy;

(x) transportation services;

(xi) case management;

(xii) prosthetics, orthotics, durable medical equipment, or medical supplies;

(xiii) dental services;

(xiv) hospice care;

(xv) audiology services and hearing aids;

(xvi) podiatry services;

(xvii) chiropractic services;

(xviii) immunizations;

(xix) vision services and eyeglasses;

(xx) waiver services;

(xxi) individualized education programs; or

(xxii) substance use disorder treatment.

(i) Pregnant noncitizens who are ineligible for federally funded medical assistance because of immigration status, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and 12 months postpartum.

(j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible

for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance. The nonprofit center referenced under this paragraph may establish itself as a provider of mental health targeted case management services through a county contract under section 256.0112, subdivision 6. If the nonprofit center is unable to secure a contract with a lead county in its service area, then, notwithstanding the requirements of section 256B.0625, subdivision 20, the commissioner may negotiate a contract with the nonprofit center for provision of mental health targeted case management services. When serving clients who are not the financial responsibility of their contracted lead county, the nonprofit center must gain the concurrence of the county of financial responsibility prior to providing mental health targeted case management services for those clients.

(k) Notwithstanding paragraph (h), clause (2), the following services are covered as emergency medical conditions under paragraph (f) except where coverage is prohibited under federal law for services under clauses (1) and (2):

(1) dialysis services provided in a hospital or freestanding dialysis facility;

(2) surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission and requires surgery, chemotherapy, or radiation treatment; and

(3) kidney transplant if the person has been diagnosed with end stage renal disease, is currently receiving dialysis services, and is a potential candidate for a kidney transplant.

(l) Effective July 1, 2013, recipients of emergency medical assistance under this subdivision are eligible for coverage of the elderly waiver services provided under chapter 256S, and coverage of rehabilitative services provided in a nursing facility. The age limit for elderly waiver services does not apply. In order to qualify for coverage, a recipient of emergency medical assistance is subject to the assessment and reassessment requirements of section 256B.0911. Initial and continued enrollment under this paragraph is subject to the limits of available funding.

EFFECTIVE DATE. This section is effective October 1, 2026.

Sec. 8. Minnesota Statutes 2024, section 256B.061, is amended to read:

256B.061 ELIGIBILITY; RETROACTIVE EFFECT; RESTRICTIONS.

(a) If any individual has been determined to be eligible for medical assistance under section 256B.055, subdivision 15, it will be made available for care and services included under the plan and furnished in or after the ~~third~~ first month before the month in which the individual made application for such assistance~~,~~ if such individual was, or upon application would have been, eligible for medical assistance at the time the care and services were furnished. If any individual has been determined to be eligible for medical assistance under any other section, it will be made available for care and services included under the plan and furnished in or after the second month before the month in which the individual made application for such assistance if such individual was, or upon application would have been, eligible for medical assistance at the time the care and services were furnished.

(b) The commissioner may limit, restrict, or suspend the eligibility of an individual for up to one year upon that individual's conviction of a criminal offense related to application for or receipt of medical assistance benefits.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 9. Minnesota Statutes 2024, section 256B.69, subdivision 5a, is amended to read:

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

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

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must

consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) The commissioner shall require that managed care plans:

(1) use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659 and community first services and supports under section 256B.85;

(2) by January 30 of each year that follows a rate increase for any aspect of services under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over rates determined under section 256B.851 of the amount of the rate increase that is paid to each personal care assistance provider agency with which the plan has a contract; and

(3) use a six-month timely filing standard and provide an exemption to the timely filing timeliness for the resubmission of claims where there has been a denial, request for more information, or system issue.

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

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

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

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

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

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

(k) Beginning January 1, 2027, a contract between the commissioner and a prepaid health plan or a county-based purchasing plan under section 256B.692 must include a requirement for the prepaid health plan or county-based purchasing plan to promptly transmit to the commissioner any address information received directly from enrollees or verified by the prepaid health plan or county-based purchasing plan directly with an enrollee.

Sec. 10. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; NOTIFICATION TO MEDICAL ASSISTANCE RECIPIENTS.**

By October 1, 2026, the commissioner of human services must notify medical assistance recipients who are enrolled under Minnesota Statutes, section 256B.055, subdivision 15, that they may be eligible for medical assistance under a disability determination. The notification must include information about how the recipient can request a determination of disability and an explanation about the changes to medical assistance eligibility that go into effect January 1, 2027.