A bill for an act

relating to human services; modifying service delivery and payment methods under medical assistance and MinnesotaCare; modifying covered services and cost-sharing requirements; making other changes related to health care; amending Minnesota Statutes 2010, sections 62J.04, subdivision 9; 62J.692, subdivision 9; 62Q.32; 62U.04, subdivision 3; 62U.06, subdivision 2; 256.969, by adding a subdivision; 256B.03, subdivision 1; 256B.05, by adding a subdivision; 256B.055, subdivision 15; 256B.06, subdivision 4; 256B.0625, subdivisions 8, 8a, 8e, 13e, 13h, 38, by adding subdivisions; 256B.0631, subdivisions 1, 2, 3; 256B.0751, subdivisions 1, 2, 3, 4, by adding subdivisions; 256B.0753, by adding a subdivision; 256B.0754, by adding a subdivision; 256B.0755, subdivision 4, by adding subdivisions; 256B.0756; 256B.37, subdivision 5; 256B.69, subdivisions 3a, 4, 6, by adding a subdivision; 256B.692, subdivisions 2, 5, 7, by adding a subdivision; 256B.694; 256L.01, subdivision 4a; 256L.02, subdivision 3; 256L.03, subdivision 5; 256L.05, subdivisions 2, 3a; 256L.07, subdivision 1; 256L.09, subdivision 4; 256L.15, subdivisions 1a, 2; proposing coding for new law in Minnesota Statutes, chapters 62J; 145; 256B; repealing Minnesota Statutes 2010, sections 62J.07, subdivisions 1, 2, 3; 256.01, subdivision 2b; Laws 2009, chapter 79, article 5, sections 64; 65; 68.

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

Section 1. Minnesota Statutes 2010, section 62J.04, subdivision 9, is amended to read:

Subd. 9. **Growth limits; federal programs.** The commissioners of health and human services shall establish a rate methodology for Medicare and Medicaid risk-based contracting with health plan companies that is consistent with statewide growth limits. ~~The methodology shall be presented for review by the Minnesota Health Care Commission and the Legislative Commission on Health Care Access prior to the submission of a waiver request to the Centers for Medicare and Medicaid Services and subsequent implementation of the methodology.~~

Sec. 2. Minnesota Statutes 2010, section 62J.692, subdivision 9, is amended to read:

Subd. 9. **Review of eligible providers.** The commissioner and the Medical Education and Research Costs Advisory Committee may review provider groups included in the definition of a clinical medical education program to assure that the distribution of the funds continue to be consistent with the purpose of this section. The results of any such reviews must be reported to the ~~Legislative Commission on Health Care Access~~ chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance.

Sec. 3. **[62J.824] BILLING FOR PROCEDURES TO CORRECT MEDICAL ERRORS IS PROHIBITED.**

A health care provider shall not bill a patient, and shall not be reimbursed, for any operation, treatment, or other care that is provided to reverse, correct, or otherwise minimize the affects of an adverse health care event, as described in section 144.7065, subdivisions 2 to 7, for which that health care provider is responsible.

Sec. 4. Minnesota Statutes 2010, section 62Q.32, is amended to read:

62Q.32 LOCAL OMBUDSPERSON.

County board or community health service agencies may establish an office of ombudsperson to provide a system of consumer advocacy for persons receiving health care services through a health plan company. The ombudsperson's functions may include, but are not limited to:

(a) mediation or advocacy on behalf of a person accessing the complaint and appeal procedures to ensure that necessary medical services are provided by the health plan company; and

(b) investigation of the quality of services provided to a person and determine the extent to which quality assurance mechanisms are needed or any other system change may be needed. ~~The commissioner of health shall make recommendations for funding these functions including the amount of funding needed and a plan for distribution. The commissioner shall submit these recommendations to the Legislative Commission on Health Care Access by January 15, 1996.~~

Sec. 5. Minnesota Statutes 2010, section 62U.04, subdivision 3, is amended to read:

Subd. 3. **Provider peer grouping.** (a) The commissioner shall develop a peer grouping system for providers based on a combined measure that incorporates both provider risk-adjusted cost of care and quality of care, and for specific conditions as determined by the commissioner. In developing this system, the commissioner shall

consult and coordinate with health care providers, health plan companies, state agencies, and organizations that work to improve health care quality in Minnesota. For purposes of the final establishment of the peer grouping system, the commissioner shall not contract with any private entity, organization, or consortium of entities that has or will have a direct financial interest in the outcome of the system.

(b) By no later than October 15, 2010, the commissioner shall disseminate information to providers on their total cost of care, total resource use, total quality of care, and the total care results of the grouping developed under this subdivision in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. Providers may be given any data for which they are the subject of the data. The provider shall have 30 days to review the data for accuracy and initiate an appeal as specified in paragraph (d).

(c) By no later than January 1, 2011, the commissioner shall disseminate information to providers on their condition-specific cost of care, condition-specific resource use, condition-specific quality of care, and the condition-specific results of the grouping developed under this subdivision in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. Providers may be given any data for which they are the subject of the data. The provider shall have 30 days to review the data for accuracy and initiate an appeal as specified in paragraph (d).

(d) The commissioner shall establish an appeals process to resolve disputes from providers regarding the accuracy of the data used to develop analyses or reports. When a provider appeals the accuracy of the data used to calculate the peer grouping system results, the provider shall:

(1) clearly indicate the reason they believe the data used to calculate the peer group system results are not accurate;

(2) provide evidence and documentation to support the reason that data was not accurate; and

(3) cooperate with the commissioner, including allowing the commissioner access to data necessary and relevant to resolving the dispute.

If a provider does not meet the requirements of this paragraph, a provider's appeal shall be considered withdrawn. The commissioner shall not publish results for a specific provider under paragraph (e) or (f) while that provider has an unresolved appeal.

(e) Beginning January 1, 2011, the commissioner shall, no less than annually, publish information on providers' total cost, total resource use, total quality, and the results of the total care portion of the peer grouping process. The results that are published must be on a risk-adjusted basis.

(f) Beginning March 30, 2011, the commissioner shall no less than annually publish information on providers' condition-specific cost, condition-specific resource use, and condition-specific quality, and the results of the condition-specific portion of the peer grouping process. The results that are published must be on a risk-adjusted basis.

(g) Prior to disseminating data to providers under paragraph (b) or (c) or publishing information under paragraph (e) or (f), the commissioner shall ensure the scientific validity and reliability of the results according to the standards described in paragraph (h). If additional time is needed to establish the scientific validity and reliability of the results, the commissioner may delay the dissemination of data to providers under paragraph (b) or (c), or the publication of information under paragraph (e) or (f). If the delay is more than 60 days, the commissioner shall report in writing to the ~~Legislative Commission on Health Care Access~~ chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance the following information:

(1) the reason for the delay;

(2) the actions being taken to resolve the delay and establish the scientific validity and reliability of the results; and

(3) the new dates by which the results shall be disseminated.

If there is a delay under this paragraph, the commissioner must disseminate the information to providers under paragraph (b) or (c) at least 90 days before publishing results under paragraph (e) or (f).

(h) The commissioner's assurance of valid and reliable clinic and hospital peer grouping performance results shall include, at a minimum, the following:

(1) use of the best available evidence, research, and methodologies; and

(2) establishment of an explicit minimum reliability threshold developed in collaboration with the subjects of the data and the users of the data, at a level not below nationally accepted standards where such standards exist.

In achieving these thresholds, the commissioner shall not aggregate clinics that are not part of the same system or practice group. The commissioner shall consult with and solicit feedback from representatives of physician clinics and hospitals during the peer grouping data analysis process to obtain input on the methodological options prior to final analysis and on the design, development, and testing of provider reports.

Sec. 6. Minnesota Statutes 2010, section 62U.06, subdivision 2, is amended to read:

Subd. 2. **Legislative oversight.** Beginning January 15, 2009, the commissioner of health shall submit to the ~~Legislative Commission on Health Care Access~~ chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance periodic progress reports on the implementation of this chapter and sections 256B.0751 to 256B.0754.

Sec. 7. **[145.9271] COMMUNITY MENTAL HEALTH CENTERS.**

Subdivision 1. **Definitions.** For purposes of this section, "community mental health center" means an entity that is eligible to receive payment under section 256B.0625, subdivision 5.

Subd. 2. **Allocation of subsidies.** The commissioner of health shall distribute subsidies to community mental health centers operating in Minnesota to continue, expand, and improve community mental health center services to low-income populations. The commissioner shall distribute the funds appropriated for this purpose to community mental health centers operating in Minnesota as of July 1, 2011. The amount of each subsidy shall be in proportion to each community mental health center's revenues received from state health care programs in the most recent calendar year for which data is available.

Sec. 8. Minnesota Statutes 2010, section 256.969, is amended by adding a subdivision to read:

Subd. 31. **Initiatives to reduce incidence of low birth-weight.** The commissioner shall require level III pediatric hospitals located in the seven-county metropolitan area, as a condition of contract, to implement strategies to reduce the incidence of low birth-weight in geographic areas identified by the commissioner as having a higher than average incidence of low birth-weight, with special emphasis on areas within a one-mile radius of the hospital. These strategies may focus on smoking prevention and cessation, ensuring that pregnant women get adequate nutrition, and addressing demographic, social, and environmental risk factors. The strategies must coordinate health care with social services and the local public health system, and offer patient education through appropriate means. The commissioner shall require hospitals to submit proposed initiatives for approval to the commissioner by January 1, 2012, and the commissioner shall require hospitals to implement approved initiatives by July 1, 2012. The commissioner shall evaluate the strategies adopted to reduce low birth-weight, and shall require hospitals to submit outcome and other data necessary for the evaluation.

Sec. 9. Minnesota Statutes 2010, section 256B.03, subdivision 1, is amended to read:

Subdivision 1. **General limit.** (a) All payments for medical assistance hereunder must be made to the vendor. The maximum payment for new vendors enrolled in the medical assistance program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(b) The medical assistance payment for vendors located outside the state shall not exceed the medical assistance payment applicable to in-state vendors for the same or similar service.

Sec. 10. Minnesota Statutes 2010, section 256B.05, is amended by adding a subdivision to read:

Subd. 4. **Technical assistance.** The commissioner shall provide technical assistance to county agencies in processing complex medical assistance applications, including but not limited to applications for long-term care services. The commissioner shall provide this technical assistance using existing financial resources.

Sec. 11. Minnesota Statutes 2010, section 256B.055, subdivision 15, is amended to read:

Subd. 15. **Adults without children.** (a) Medical assistance may be paid for a person who is:

(1) at least age 21 and under age 65;

(2) not pregnant;

(3) not entitled to Medicare Part A or enrolled in Medicare Part B under Title XVIII of the Social Security Act;

(4) not an adult in a family with children as defined in section 256L.01, subdivision 3a; and

(5) not described in another subdivision of this section.

(b) If the federal government eliminates the federal Medicaid match, or reduces the federal Medicaid matching rate beyond any adjustment required as part of the annual recalculation of the state's overall Medicaid matching rate, for persons eligible under this subdivision, the commissioner shall eliminate coverage for persons enrolled under this subdivision, and suspend new enrollment under this subdivision, effective on the date of the elimination or reduction.

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

Sec. 12. Minnesota Statutes 2010, 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. 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) 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.

(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) All 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 financial participation through November 30, 1996.

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:

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

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

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

(iv) 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

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

Beginning December 1, 1996, qualified noncitizens who do not meet one of the criteria in items (i) to (v) are eligible for medical assistance without federal financial participation as described in paragraph (j).

Notwithstanding paragraph (j), beginning July 1, 2010, children and pregnant women who are noncitizens described in paragraph (b) or (e), 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) Noncitizens who are not qualified noncitizens as defined in paragraph (b), who are lawfully present in the United States, as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance under clauses (1) to (3). These individuals must cooperate with the United States Citizenship and Immigration Services to pursue any applicable immigration status, including citizenship, that would qualify them for medical assistance with federal financial participation.

(1) Persons who were medical assistance recipients on August 22, 1996, are eligible for medical assistance with federal financial participation through December 31, 1996.

(2) Beginning January 1, 1997, persons described in clause (1) are eligible for medical assistance without federal financial participation as described in paragraph (j).

(3) Beginning December 1, 1996, persons residing in the United States prior to August 22, 1996, who were not receiving medical assistance and persons who arrived on or after August 22, 1996, are eligible for medical assistance without federal financial participation as described in paragraph (j).

(f) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (g) to (i). 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).

(g) 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~~, except for organ transplants and related care and services and routine prenatal care~~.

(h) 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).

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

(1) services delivered in an emergency room that are directly related to the treatment of an emergency medical condition;

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

(3) 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.

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

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

(2) organ transplants and related care;

(3) services for routine prenatal care;

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

(5) elective surgery;

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

(7) preventative health care and family planning services;

(8) dialysis;

(9) chemotherapy or therapeutic radiation services;

(10) rehabilitation services;

(11) physical, occupational, or speech therapy;

(12) transportation services;

(13) case management;

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

(15) dental services;

(16) hospice care;

(17) audiology services and hearing aids;

(18) podiatry services;

(19) chiropractic services;

(20) immunizations;

(21) vision services and eyeglasses;

(22) waiver services;

(23) individualized education programs; or

(24) chemical dependency treatment.

~~(i)~~ (j) Beginning July 1, 2009, pregnant noncitizens who are undocumented, nonimmigrants, or lawfully present as designated in paragraph (e) and who 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 60 days postpartum, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program.

~~(j)~~ (k) Qualified noncitizens as described in paragraph (d), and all other noncitizens lawfully residing in the United States as described in paragraph (e), who are ineligible for medical assistance with federal financial participation and who otherwise meet the eligibility requirements of chapter 256B and of this paragraph, are eligible for medical assistance without federal financial participation. Qualified noncitizens as described in paragraph (d) are only eligible for medical assistance without federal financial participation for five years from their date of entry into the United States.

~~(k)~~ (l) 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.

Sec. 13. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 1b. **Care coordination services provided through pediatric hospitals.** (a) Medical assistance covers care coordination services provided by advanced practice nurses employed by or under contract with level III pediatric hospitals, to children with high-cost medical conditions and children at risk of recurrent hospitalization for acute or chronic illnesses. The services must be available through in-home video telehealth management and other methods, and must be designed to improve patient outcomes and reduce unnecessary hospital and emergency room utilization. The services must streamline communication, reduce redundancy, and eliminate unnecessary documentation through the use of a web-accessible, uniform document that contains critical patient care management information, and which is accessible to all providers with patient consent. The commissioner shall develop the uniform document and associated website, and shall implement procedures to assess patient outcomes and evaluate the effectiveness of the care coordination services provided under this subdivision.

(b) Medical assistance also covers, as durable medical equipment, computers, webcams, and other technology necessary to allow in-home video telehealth management.

(c) For purposes of this subdivision, a child has a high-cost medical condition if inpatient hospital expenses for that child related to complex or chronic illnesses or conditions for the most recent calendar year exceeded $100,000 or if these expenses for that child are projected to exceed $100,000 for the current calendar year. For purposes of this subdivision, a child is at risk of recurrent hospitalization if the child was hospitalized three or more times for acute or chronic illness in the most recent calendar year.

(d) For purposes of this subdivision, "care coordination" means collaboration between the advanced practice nurse and primary care physicians and specialists to manage care and reduce hospitalizations, patient case management, development of medical management plans for chronic illnesses and recurrent acute illnesses, oversight and coordination of all aspects of care in partnership with families, organization of medical information into a summary of critical information, coordination and appropriate sequencing of tests and multiple appointments, information and assistance with accessing resources, and telephone triage for acute illnesses or problems.

(e) The commissioner shall adjust managed care and county-based purchasing plan capitation rates to reflect savings from the coverage of this service.

EFFECTIVE DATE. This section is effective January 1, 2012.

Sec. 14. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 3g. **Elective inductions of labor.** Medical assistance does not cover elective inductions of labor prior to 39 weeks gestation. For purposes of this subdivision, "elective induction of labor" means the use of artificial means to stimulate labor in a woman without the presence of a medical condition affecting the woman or the child that makes the induction of labor a medical necessity or emergency.

Sec. 15. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 4b. **Repeat testing.** (a) The commissioner shall identify diagnostic imaging tests, laboratory tests, and other medical tests with a high potential for unnecessary repeated testing. For those tests identified, repeat medical tests are not covered for the same condition or diagnosis, unless prior authorization is obtained from the commissioner or a protocol developed by the commissioner to minimize unnecessary repeat testing is used. For purposes of this requirement, a "repeat medical test" is one that is ordered by a health care provider, or requested by an enrollee, within 30 days of an identical or similar test being performed, or within six months if there is minimal likelihood of significant change in the findings of the test, were the test to be repeated.

(b) The commissioner shall reduce capitation rates to managed care and county-based purchasing plans providing services under sections 256B.69 and 256B.692, to reflect cost-savings resulting from implementation of this subdivision.

Sec. 16. Minnesota Statutes 2010, section 256B.0625, subdivision 8, is amended to read:

Subd. 8. **Physical therapy.** Medical assistance covers physical therapy and related services, including specialized maintenance therapy. Authorization by the commissioner is required to provide medically necessary services to a recipient beyond any of the following onetime service thresholds, or a lower threshold where one has been established by the commissioner for a specified service: (1) 80 units of any approved CPT code other than modalities; (2) 20 modality sessions; and (3) three evaluations or reevaluations. ~~Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises.~~ Services provided by a physical therapy assistant that are provided under the direction of a physical therapist ~~who is not on the premises~~ shall be reimbursed at 65 percent of the physical therapist rate.

Sec. 17. Minnesota Statutes 2010, section 256B.0625, subdivision 8a, is amended to read:

Subd. 8a. **Occupational therapy.** Medical assistance covers occupational therapy and related services, including specialized maintenance therapy. Authorization by the commissioner is required to provide medically necessary services to a recipient beyond any of the following onetime service thresholds, or a lower threshold where one has been established by the commissioner for a specified service: (1) 120 units of any combination of approved CPT codes; and (2) two evaluations or reevaluations. ~~Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises.~~ Services provided by an occupational therapy assistant that are provided under the direction of an occupational therapist ~~who is not on the premises~~ shall be reimbursed at 65 percent of the occupational therapist rate.

Sec. 18. Minnesota Statutes 2010, section 256B.0625, subdivision 8e, is amended to read:

Subd. 8e. **Chiropractic services.** Payment for chiropractic services is limited to one annual evaluation and ~~12~~ 24 visits per year unless prior authorization of a greater number of visits is obtained.

Sec. 19. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 8f. **Acupuncture services.** Medical assistance covers acupuncture, as defined in section 147B.01, subdivision 3, only when provided by a licensed acupuncturist, or by another Minnesota licensed practitioner for whom acupuncture is within the practitioner's scope of practice and who has specific acupuncture training or credentialing.

Sec. 20. Minnesota Statutes 2010, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical

assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. ~~Effective July 1, 2009,~~ The actual acquisition cost of a drug shall be estimated by the commissioner, at ~~average wholesale price minus 15 percent~~ wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four category classification of the Rural Urban Commuting Area system developed for the U.S. Health Resources and Services Administration. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be on the basis of the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted

according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider or the amount established for Medicare by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

EFFECTIVE DATE. This section is effective July 1, 2011, or upon federal approval, whichever is later.

Sec. 21. Minnesota Statutes 2010, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking ~~four~~ three or more prescriptions to treat or prevent ~~two~~ one or more chronic medical conditions, or a recipient with a drug therapy problem that is identified by

the commissioner, or identified by a pharmacist and approved by the commissioner, or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

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

(2) formulating a medication treatment plan;

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

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

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

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

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

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

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

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

(1) have a valid license issued under chapter 151;

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

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, ~~excluding~~ including long-term care ~~and~~ settings, group homes,

~~if the service is ordered by the provider-directed care coordination team~~ and facilities providing assisted living services; and

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

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

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

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

EFFECTIVE DATE. This section is effective July 1, 2011.

Sec. 22. Minnesota Statutes 2010, section 256B.0625, subdivision 38, is amended to read:

Subd. 38. **Payments for mental health services.** Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. ~~Payments for mental health services covered under~~

~~the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals.~~ For purposes of reimbursement of mental health professionals under the medical assistance program, all social workers who:

(1) have received a master's degree in social work from a program accredited by the Council on Social Work Education;

(2) are licensed at the level of graduate social worker or independent social worker; and

(3) are practicing clinical social work under appropriate supervision, as defined by chapter 148D; meet all requirements under Minnesota Rules, part 9505.0323, subpart 24, and shall be paid accordingly.

Sec. 23. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 55. **Payment for multiple services provided on the same day.** The commissioner shall not prohibit payment, including any supplemental payments, for mental health services or dental services provided to a patient by a clinic or health care professional, solely because the mental health or dental services were provided on the same day as other covered health care services furnished by the same provider.

Sec. 24. Minnesota Statutes 2010, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. ~~**Co-payments**~~ **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following ~~co-payments~~ cost-sharing for all recipients, effective for services provided on or after ~~October 1, 2003, and before January 1, 2009~~ July 1, 2011:

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

(2) $3 for eyeglasses;

(3) ~~$6~~ $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval; ~~and~~

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a ~~$12~~ $20 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness~~.~~ ;

(5) a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54; and

~~(b) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after January 1, 2009:~~

~~(1) $3.50 for nonemergency visits to a hospital-based emergency room;~~

~~(2) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $7 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and~~

~~(3)~~ (6) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly ~~co-payments~~ cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on ~~co-payments~~ cost-sharing.

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

(c) Effective January 1, 2012, or upon federal approval, whichever is later, the following co-payments for nonpreventive visits shall apply:

(1) $3 for visits to providers whose average, risk-adjusted, total annual cost of care per medical assistance enrollee is at the 60th percentile or lower for providers of the same type;

(2) $6 for visits to providers whose average, risk-adjusted, total annual cost of care per medical assistance enrollee is greater than the 60th percentile but does not exceed the 80th percentile for providers of the same type; and

(3) $10 for visits to providers whose average, risk-adjusted, total annual cost of care per medical assistance enrollee is greater than the 80th percentile for providers of the same type.

Each managed care and county based purchasing plan shall calculate the average, risk-adjusted, total annual cost of care for providers under this paragraph, using a methodology that has been approved by the commissioner. The commissioner shall develop a methodology for calculating the average, risk-adjusted, total annual cost of care for fee-for-service providers.

(d) The commissioner shall seek any federal waivers and approvals necessary to increase the co-payment for nonemergency visits to a hospital-based emergency room under paragraph (a), clause (3) and implement paragraph (c).

Sec. 25. Minnesota Statutes 2010, section 256B.0631, subdivision 2, is amended to read:

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

(1) children under the age of 21;

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

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

(4) recipients receiving hospice care;

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

(6) emergency services;

(7) family planning services;

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

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

Sec. 26. Minnesota Statutes 2010, section 256B.0631, subdivision 3, is amended to read:

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

(1) once a recipient has reached the ~~$12~~ $20 per month maximum ~~or the $7 per month maximum effective January 1, 2009,~~ for prescription drug co-payments; or

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

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

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

Sec. 27. Minnesota Statutes 2010, section 256B.0751, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of sections 256B.0751 to 256B.0753, the following definitions apply.

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

(c) "Commissioners" means the commissioner of humans services and the commissioner of health, acting jointly.

(d) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

(e) "Personal clinician" means a physician licensed under chapter 147, a physician assistant licensed and practicing under chapter 147A, a mental health professional licensed under section 245.462, subdivision 18, paragraphs (1) to (6), or section 245.4871, subdivision 27, paragraphs (1) to (6); ~~or~~ an advanced practice nurse licensed and registered to practice under chapter 148, or a chiropractor working in cooperation with a physician, physician assistant, or advanced practice nurse.

(f) "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Sec. 28. Minnesota Statutes 2010, section 256B.0751, subdivision 2, is amended to read:

Subd. 2. **Development and implementation of standards.** (a) By July 1, 2009, the commissioners of health and human services shall develop and implement standards of certification for health care homes for state health care programs. In developing these standards, the commissioners shall consider existing standards developed by national independent accrediting and medical home organizations. The standards developed by the commissioners must meet the following criteria:

(1) emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, mental health professionals, ~~and~~ physician assistants, and chiropractors as personal clinicians but permitting multidisciplinary teams of other health professionals;

(2) focus on delivering high-quality, efficient, and effective health care services and providing, arranging, or coordinating related social and public health services and other services that directly affect an individual's health, access to services, quality and outcomes, and patient satisfaction;

(3) encourage patient-centered care and services, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter

145C, as appropriate in decision making and care plan development, and providing care that is appropriate to the patient's race, ethnicity, and language;

(4) provide patients with a consistent, ongoing contact with a personal clinician or team of ~~clinical~~ professionals to ensure continuous and appropriate care for the patient's condition;

(5) ensure that health care homes develop and maintain appropriate comprehensive care and wellness plans for their patients with complex or chronic conditions, including an assessment of health risks, ~~and~~ chronic conditions, and socio-economic factors affecting health and treatment;

(6) enable and encourage utilization of a range of qualified health care professionals and other professionals or services related to the health and treatment of the patient, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;

(7) focus initially on patients who have or are at risk of developing chronic health conditions;

(8) incorporate measures of quality, resource use, cost of care, and patient experience, with appropriate adjustments for socioeconomic factors;

(9) ensure the use of health information technology and systematic follow-up, including the use of patient registries; and

(10) encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment and service options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

(b) In developing these standards, the commissioners shall consult with national and local organizations working on health care home models, physicians, relevant state agencies, health plan companies, hospitals, other providers, patients, and patient advocates. The commissioners may satisfy this requirement by continuing the provider directed care coordination advisory committee.

(c) For the purposes of developing and implementing these standards, the commissioners may use the expedited rulemaking process under section 14.389.

Sec. 29. Minnesota Statutes 2010, section 256B.0751, subdivision 3, is amended to read:

Subd. 3. **Requirements for clinicians certified as health care homes.** (a) A personal clinician, ~~or~~ a primary care clinic, or community mental health center eligible for payment under section 256B.0625, subdivision 5, may be certified as a health care home.

If a primary care clinic or mental health center is certified, all of the primary care clinic's or mental health center's clinicians who may provide care to persons enrolled with the health care home must meet the criteria of a health care home. In order to be certified as a health care home, a clinician, ~~or~~ clinic, or community mental health center must meet the standards set by the commissioners in accordance with this section. Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually.

(b) Clinicians, ~~or~~ clinics, or mental health centers certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

(c) Health care homes must participate in the health care home collaborative established under subdivision 5.

Sec. 30. Minnesota Statutes 2010, section 256B.0751, subdivision 4, is amended to read:

Subd. 4. **Alternative models and waivers of requirements.** (a) Nothing in this section shall preclude the continued development of existing medical or health care home projects currently operating or under development by the commissioner of human services or preclude the commissioner from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs under section 256B.69, subdivisions 23 and 28, are enrolled in managed care long-term care programs under section 256B.69, subdivision 6b, are dually eligible for Medicare and medical assistance, are in the waiting period for Medicare, or who have other primary coverage.

(b) The commissioner of health shall modify the health care homes application for certification to add an item allowing an applicant to indicate status as a federally qualified health center or a federally qualified health center look-alike, as defined in section 145.9269, subdivision 1. The commissioner shall certify as a health care home each applicant that indicates this status on a completed application for certification, without requiring the applicant to meet the standards in Minnesota Rules, part 4764.0040. In order to retain certification, a federally qualified health center or federally qualified health center look-alike certified under this paragraph must seek annual recertification by submitting a letter of intent stating its desire to be recertified but is not required to meet the standards for recertification in Minnesota Rules, part 4764.0040.

(c) The commissioner of health shall waive health care home certification requirements if an applicant demonstrates that compliance with a certification requirement

will create a major financial hardship or is not feasible, and the applicant establishes an alternative way to accomplish the objectives of the particular certification requirement.

Sec. 31. Minnesota Statutes 2010, section 256B.0751, is amended by adding a subdivision to read:

Subd. 8. **Coordination with local services.** The health care home and the county shall coordinate care and services provided to patients enrolled with a health care home who have complex medical or socio-economic needs or a disability, and who need and are eligible for additional local services administered by counties, including but not limited to: waivered services, mental health services, social services, public health services, transportation, and housing. The coordination of care and services must be as provided in the plan established by the patient and health care home.

Sec. 32. Minnesota Statutes 2010, section 256B.0751, is amended by adding a subdivision to read:

Subd. 9. **Patient choice of health care home.** Notwithstanding section 256B.69, subdivisions 4 and 23, and subject to any necessary federal approval, the commissioner may require a patient enrolled in a state health care program through a managed care plan, county-based purchasing plan, fee-for-service, or demonstration project under section 256B.0755 to select a health care home and agree to receive primary care and care coordination services through the health care home as a condition of enrollment in the state health care program. The patient must be allowed to choose from among all available qualified health care providers, including an essential community provider as defined in section 62Q.19, if the provider is certified as a health care home and agrees to accept the terms, conditions and payment rates for participation in the managed care plan, county-based purchasing plan, fee-for-service program, or demonstration project, except that reimbursement to federally qualified health centers and federally qualified health center look-alikes as defined in section 145.9269 must be in compliance with federal law.

Sec. 33. Minnesota Statutes 2010, section 256B.0751, is amended by adding a subdivision to read:

Subd. 10. **Engagement of patients and communities in health care home.** The commissioner of health shall require health care homes to demonstrate that their health care home patients, and the racial and ethnic communities of current or potential patients, participate in evaluating the health care home and recommending improvements and changes to the health care home's methods and procedures, in order to improve health,

quality, and patient satisfaction for patients from those communities. The commissioner shall consult with racial and ethnic communities to determine whether the requirements of this section and rules adopted under it are barriers to effective health care home methods and procedures for serving patients of racial and ethnic communities.

Sec. 34. Minnesota Statutes 2010, section 256B.0753, is amended by adding a subdivision to read:

Subd. 4. **Waiver recipients.** A health care home shall receive the highest care coordination payment established under section 256B.0753, for providing services to an enrollee receiving home and community-based waiver services.

Sec. 35. Minnesota Statutes 2010, section 256B.0754, is amended by adding a subdivision to read:

Subd. 3. **Primary care provider tiering.** (a) The commissioner shall establish a tiering system for all providers participating in Minnesota health care programs. The tiering system must differentiate providers on the basis of their ability to provide cost-effective, quality care and must incorporate the provider peer grouping measures established under section 62U.04. The tier assignments must be established annually based on the most recent peer grouping measures available. Differentiation of tier assignments must be statistically valid. The commissioner may set specific quality standards for providers designated as high-performing providers under this subdivision.

(b) The commissioner may adjust the rates paid to providers within each tier group established under paragraph (a) on an annual basis. Adjustments to rates shall not include the rate paid for care coordination services to certified health care homes (HCH) under section 256B.0753. Providers designated high-performing providers under paragraph (c) are not eligible for rate increases unless the provider also meets the cost and quality criteria associated with that tier level.

(c) Health care homes certified under section 256B.0751, rural health clinics, and federally qualified health care clinics are designated as high-performing providers under this subdivision.

(d) Providers reimbursed on a cost basis are subject to rate adjustments under this section.

(e) The commissioner may phase in the tiering system by service type.

EFFECTIVE DATE. This section is effective one year from the public release of provider peer grouping measures under Minnesota Statutes, section 62U.04, or upon federal approval, whichever is later.

Sec. 36. Minnesota Statutes 2010, section 256B.0755, subdivision 4, is amended to read:

Subd. 4. **Payment system.** (a) In developing a payment system for health care delivery systems, the commissioner shall establish a total cost of care benchmark or a risk/gain sharing payment model to be paid for services provided to the recipients enrolled in a health care delivery system.

(b) The payment system may include incentive payments to health care delivery systems that meet or exceed annual quality and performance targets realized through the coordination of care.

(c) An amount equal to the savings realized to the general fund as a result of the demonstration project shall be transferred each fiscal year to the health care access fund.

(d) The total cost of care benchmark for demonstration projects must be no greater than the capitation rate that would have been paid to a managed care plan for a substantially similar enrollee population based on the per-member per-month rate in effect on December 31, 2010. The commissioner shall adjust benchmark payment rates for demonstration projects as necessary to reflect the higher level of service and cost necessary to serve a patient population with a higher incidence of socioeconomic barriers and complexity, and shall make corresponding reductions in payment rates for projects with a lower concentration of patients with socioeconomic barriers and complexity.

Sec. 37. Minnesota Statutes 2010, section 256B.0755, is amended by adding a subdivision to read:

Subd. 8. **Coordination with local services.** The health care home and the county shall coordinate care and services provided to patients enrolled in a demonstration project who have complex medical or socioeconomic needs or a disability, and who need and are eligible for additional local services administered by counties, including but not limited to: waivered services, mental health services, social services, public health services, transportation or housing. The coordination of care and services must as provided in the plan established by the patient and primary care provider or health care home.

Sec. 38. Minnesota Statutes 2010, section 256B.0755, is amended by adding a subdivision to read:

Subd. 8. **Rural Demonstration Projects.** For demonstration projects serving rural areas, the commissioner shall consult with rural hospitals, primary care providers, county boards, health plans, and other key stakeholders primarily domiciled in the service area regarding the development and approval of alternative rural health care

delivery demonstration projects under this section. In addition to organizations eligible to establish a demonstration project under subdivision 1, a rural demonstration project may be established by a county public health or social services agencies or a county-based purchasing plan. In a rural area where multiple, competing provider-based demonstration projects are not possible, the commissioner shall not approve more than one demonstration project to serve the primary geographic area and shall follow the applicable procedures and requirements in section 256B.692 regarding participation of county boards in reviewing and approving demonstration project proposals.

Sec. 39. Minnesota Statutes 2010, section 256B.0755, is amended by adding a subdivision to read:

Subd. 9. **Patient choice of qualified provider.** The commissioner shall implement and approve demonstration projects in a manner that allows a patient to choose a primary care provider and health care home from among all available qualified options. The commissioner may require the patient to remain with the chosen provider, health care home or demonstration project organization for a period of time determined by the commissioner. The commissioner shall implement the demonstration projects in a manner that ensures that a patient has the option of receiving services, including health care home services, through a provider designated as an essential community provider under section 62Q.19, if the provider is qualified to provide the services and agrees to accept the terms, conditions and payment rates for participation in the demonstration project, except that reimbursement to federally qualified health centers and federally qualified health center look-alikes as defined in section 145.9269 must be in compliance with federal law.

Sec. 40. Minnesota Statutes 2010, section 256B.0755, is amended by adding a subdivision to read:

Subd. 10. **Patient and community engagement.** As a condition of approval of a demonstration project, the commissioner shall require the applicant to demonstrate that consumers and communities to be served under the project were consulted with and engaged in the process of developing the project proposal. The proposal must identify the needs and preferences of consumers and communities that were identified through this process of consultation and engagement. The consumers and communities consulted with and engaged in the development of the proposal must generally reflect the demographics, race, and ethnicity of those likely to be served under the demonstration project, with a special focus on those who experience the greatest health disparities. The commissioner shall require that demonstration project providers continue to consult with and engage

consumers and communities during implementation and operation of the demonstration project.

Sec. 41. Minnesota Statutes 2010, section 256B.0755, is amended by adding a subdivision to read:

Subd. 11. **Care coordination system.** The commissioner of health, in consultation with the commissioner of human services, shall convene an advisory committee of small, independent, rural and safety net primary care clinics, community hospitals, mental health centers, dental clinics, and other providers, to advise the commissioner on the establishment of a system that will allow providers participating in payment reform demonstration project established under this section and section 256B.0756 to effectively coordinate and deliver care to patients. In consultation with the advisory committee, the commissioner shall develop a plan for the care coordination system, issue a request for proposals, and contract with a vendor or vendors to establish and maintain the technology for the care coordination system. Using appropriations made for this purpose, the commissioner shall fund the planning, development and establishment of the system. Ongoing costs must be covered by payments made by the providers who use the system.

Sec. 42. Minnesota Statutes 2010, section 256B.0755, is amended by adding a subdivision to read:

Subd. 12. **Approval and implementation.** The commissioner of human services shall approve payment reform projects authorized under this section for medical assistance and MinnesotaCare, to commence on January 1, 2012. The commissioner may approve projects for persons enrolled in fee-for-service programs and may require managed care plans and county-based purchasing plans to contract with a demonstration project provider on the same terms, conditions and payment arrangements as are established by the commissioner for fee-for-service programs.

Sec. 43. Minnesota Statutes 2010, section 256B.0756, is amended to read:

256B.0756 HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.

(a) The commissioner, upon federal approval of a new waiver request or amendment of an existing demonstration, may establish a pilot program in Hennepin County or Ramsey County, or both, to test alternative and innovative integrated health care delivery networks.

(b) Individuals eligible for the pilot program shall be individuals who are eligible for medical assistance under section 256B.055, subdivision 15, and who reside in Hennepin County or Ramsey County.

(c) Individuals enrolled in the pilot program shall be enrolled in an integrated health care delivery network in their county of residence. The integrated health care delivery network in Hennepin County shall be a network, such as an accountable care organization or a community-based collaborative care network, created by or including Hennepin County Medical Center. The integrated health care delivery network in Ramsey County shall be a network, such as an accountable care organization or community-based collaborative care network, created by or including Regions Hospital.

(d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for Hennepin County and 3,500 enrollees for Ramsey County.

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

(f) Counties may transfer funds necessary to support the nonfederal share of payments for integrated health care delivery networks in their county. Such transfers per county shall not exceed 15 percent of the expected expenses for county enrollees.

(g) The commissioner shall apply to the federal government for, or as appropriate, cooperate with counties, providers, or other entities that are applying for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the creation of an integrated health care delivery network for the purposes of this subdivision, including, but not limited to, a global payment demonstration or the community-based collaborative care network grants.

(h) A demonstration project established under this section must meet the requirements of section 256B.0755, subdivisions 8, 9, 10, and 11.

Sec. 44. **[256B.0758] PREGNANCY CARE HOMES.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Pregnancy care home" means a health care home certified by the commissioner of health under section 256B.0751 that provides pregnancy care services in a way that is patient centered, outcome driven, comprehensive, and coordinated, and meets the standards specified and developed under subdivision 3.

(c) "Pregnancy care services" means prenatal care, all consultative perinatal services, intrapartum and postpartum care, and well-baby care for the first week.

(d) "State health care program" means the medical assistance and MinnesotaCare programs.

Subd. 2. **Development and implementation of standards.** (a) The commissioners of human services and health shall develop and implement standards of certification of pregnancy care homes for state health care programs. In developing standards, the commissioners shall consult with representatives of the American College of Nurse Midwives, the American Congress of OB/GYN, the American Academy of Family Practice, the American Academy of Pediatrics, and relevant local consumer groups.

Subd. 3. **Criteria for development of standards.** (a) A pregnancy care home must meet the general health care home standards developed by the commissioners under section 256B.0751, subdivision 2, clauses (1) to (4), (6), and (8) to (10), and must also meet specific standards for pregnancy care homes. The specific standards for pregnancy care homes developed by the commissioners must meet the criteria specified in this subdivision.

(b) A pregnancy care home must meet an initial threshold of at least 300 births per year for the first year, and a threshold of at least 500 births per year for the second and succeeding years. No single pregnancy health care home shall perform more than 25 percent of the total births in the state.

(c) A pregnancy care home must provide pregnancy care services. Non-pregnancy complications, such as preexisting illness, shall be covered by medical assistance outside of the pregnancy care home. During a pregnancy episode, the pregnancy care home must coordinate necessary non-pregnancy health care services with the mother's care primary provider, or another appropriate provider.

(d) Each pregnancy care home must have adequate reinsurance, that meets the standards specified by the commissioners.

(e) A pregnancy care home may provide pregnancy services through any health care professional licensed to provide the service in Minnesota, including but not limited to certified professional midwives and licensed midwives, family practitioners, obstetricians, perinatalogists, pediatricians, neonatologists, and advanced practice nurses.

(f) Pregnancy care within a pregnancy care home may be provided at any Minnesota facility licensed to provide pregnancy care and birth, including but not limited to free-standing birth centers, integrated birth centers, and hospitals. Each pregnancy care home must offer the option of midwife-directed pregnancy care services in a licensed integrated or freestanding birth center.

(g) A pregnancy care home must have a governing board comprised of at least eight members. One-half of governing board members must be providers licensed to attend births.

(h) Each pregnancy care home must have a formal consultative relationship with at least one level III perinatal center to provide care for mothers and babies who develop pregnancy complications.

(i) Each pregnancy care home must comply with state and federal requirements for the use of interoperable electronic medical records.

(j) Each pregnancy care home must submit annual reports to the commissioners of human services and health that document:

(1) all relevant pregnancy care outcomes and patient satisfaction measures; and

(2) the financial status of the pregnancy care home.

All reports are public data under section 13.02.

(k) Each pregnancy care home must offer culturally and language appropriate care coordination services in a manner that is consistent with health care home requirements.

(l) For the purposes of developing and implementing these standards, the commissioners may use the expedited rulemaking process under section 14.389.

Subd. 4. **Certification process.** Providers seeking certification as a pregnancy care home must apply to the commissioner of health. Providers certified by the commissioner of health may provide pregnancy care services through pregnancy care homes beginning July 1, 2012. Certification as a pregnancy care home is voluntary, except that beginning July 1, 2014, all nonemergency pregnancy care services covered under state health care programs must be provided through providers certified as pregnancy care homes.

Subd. 5. **Payments to pregnancy care homes.** (a) The commissioner of human services, in coordination with the commissioner of health, shall develop a payment system that provides a single per-person payment to pregnancy care homes to cover all pregnancy care services provided to each mother and infant enrolled in a state health care program. Pregnancy care homes receiving payments under this subdivision remain eligible for care coordination payments under section 256B.0753.

(b) Payment amounts for pregnancy care homes shall be uniform statewide, and determined annually by the commissioner, based initially upon a specified percentage of the calculated average cost of care for mothers and infants under state health care programs for the three most recent fiscal years for which cost information is available. Beginning July 1, 2014, statewide payments amounts for pregnancy care homes shall be determined annually by the commissioner, by adjusting the current payment amount by a measure of medical inflation selected by the commissioner that best represents the

change in the cost of pregnancy-related services provided to patients covered by private sector health coverage.

(c) Pregnancy care home payments must initially be made for pregnancy care services provided to pregnant women who are not high-risk, beginning July 1, 2012. Beginning January 1, 2013, the commissioner shall phase-in higher payments for high-risk pregnancy categories, so that beginning July 1, 2014, pregnancy care services for all low-risk and high-risk pregnancies are reimbursed under this subdivision.

Sec. 45. **[256B.0758] CARE COORDINATION FOR ENROLLEES.**

Subdivision 1. **Qualified enrollee.** For purposes of this section, a "qualified enrollee" means: (1) a medical assistance enrollee eligible under this chapter; or (2) a MinnesotaCare enrollee eligible under chapter 256L.

Subd. 2. **Selection of primary care provider.** The commissioner shall require qualified enrollees who do not have a designated medical condition to select a primary care provider, and agree to receive primary care services from that provider as a condition of medical assistance or MinnesotaCare enrollment.

Subd. 3. **Selection of health care home; care coordination.** (a) The commissioner shall require qualified enrollees who have a medical condition designated by the commissioner to select a health care home certified under section 256B.0751, and agree to receive primary care and care coordination services through that health care home as a condition of medical assistance or MinnesotaCare enrollment. For purposes of this paragraph, the commissioner shall designate those medical conditions with a high likelihood of inappropriate inpatient hospital admissions, for which care coordination and prior authorization of admissions are expected to improve the quality of care and lead to costs savings for state health care programs.

(b) The commissioner shall include on Minnesota health care program enrollment cards a designation as to whether an enrollee meets the criteria in paragraph (a). In order to receive medical assistance or MinnesotaCare payment for non-emergency inpatient hospital admissions for enrollees meeting the criteria in paragraph (a), a hospital must receive prior authorization from the enrollee's health care home.

EFFECTIVE DATE. This section is effective January 1, 2012, for MinnesotaCare enrollees not eligible for a federal match, and is effective January 1, 2012, or upon federal approval, whichever is later, for medical assistance enrollees, and for MinnesotaCare enrollees eligible for a federal match.

Sec. 46. **[256B.0759] ELECTIVE SURGERY.**

Subdivision 1. **Payment prohibition.** The commissioner, in consultation with health care providers, health care homes certified under section 256B.075, managed care plans providing services under section 256B.69, and county-based purchasing plans providing services under section 256B.692, shall identify elective or nonemergency surgical procedures for which less invasive and less costly alternative treatment methods are available, and shall prohibit payment for these elective or nonemergency surgical procedures, if these alternative treatment methods have not first been evaluated for use and if appropriate, provided to the enrollee.

Subd. 2. **Implementation.** The commissioner shall implement the payment prohibitions in paragraph (a) for fee-for-service medical assistance providers by January 1, 2012, and shall require managed care and county-based purchasing plans to implement the payment prohibitions in paragraph (a) for providers employed or under contract, for services provided to medical assistance and MinnesotaCare enrollees beginning January 1, 2012.

Subd. 3. **Reduction in capitation rates.** The commissioner shall reduce medical assistance and MinnesotaCare capitation rates to managed care and county-based purchasing plans beginning January 1, 2012, to reflect cost-savings to plans resulting from implementation of the payment prohibitions required by this subdivision.

Sec. 47. Minnesota Statutes 2010, section 256B.37, subdivision 5, is amended to read:

Subd. 5. **Private benefits to be used first.** Private accident and health care coverage, including Medicare for medical services and coverage provided through the U.S. Department of Veterans Affairs, is primary coverage and must be exhausted before medical assistance or alternative care services are paid for medical services including home health care, personal care assistance services, hospice, supplies and equipment, or services covered under a Centers for Medicare and Medicaid Services waiver. When a person who is otherwise eligible for medical assistance has private accident or health care coverage, including Medicare or a prepaid health plan or coverage provided through the U.S. Department of Veterans Affairs, the private health care benefits available to the person must be used first and to the fullest extent.

Sec. 48. Minnesota Statutes 2010, section 256B.69, subdivision 3a, is amended to read:

Subd. 3a. **County authority.** (a) The commissioner, when implementing or administering the medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county, including

proposals for demonstration projects established under section 256B.0755. County boards must be given reasonable opportunity to ~~make recommendations regarding~~ assist in the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make ~~recommendations~~ determinations regarding the approval of local networks and their operations to ensure adequate local availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance funds. The county board ~~may recommend~~ shall decide a maximum number of participating health plans including county-based purchasing plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans, managed care plans, or demonstration projects established under section 256B.0755. The county board or a single entity representing a group of county boards and the commissioner shall mutually select one or more qualified health plans or county-based purchasing plans for participation at the time of initial implementation of the prepaid medical assistance program or a demonstration project established under 256B.0755 in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process.

(b) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals and health care delivery and access goals to meet the health needs of medical assistance enrollees. These requirements must be reasonably related to the performance of health plan managed care, or delivery system demonstration project functions and within the scope of the medical assistance benefit set. ~~If the county board and the commissioner mutually agree to such requirements, the department~~ The commissioner shall include such requirements in all ~~health plan~~ contracts governing the prepaid medical assistance program in that county at initial implementation of the program or demonstration project in that county and at the time of contract renewal.

The county board may participate in the enforcement of the contract ~~provisions related to local public health goals~~.

(c) For counties in which a prepaid medical assistance program has not been established, the commissioner shall not implement that program if a county board submits an acceptable and timely preliminary and final proposal under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts a ~~preliminary and final~~ proposal according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

(d) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans or demonstration projects under section 256B.0755 in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes ~~after taking into account~~ by approving the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

(e) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

(f) The commissioner shall not require that contractual disputes between county-based purchasing entities and the commissioner be mediated by a panel that includes a representative of the Minnesota Council of Health Plans.

(g) At the request of a county-purchasing entity, the commissioner shall adopt a contract reprocurement or renewal schedule under which all counties included in the entity's service area are reprocured or renewed at the same time.

(h) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services in the senate and the

house of representatives describing in detail the activities undertaken by the commissioner to ensure full compliance with this section. The report must also provide an explanation for any decisions of the commissioner not to accept the recommendations of a county or group of counties required to be consulted under this section. The report must be provided at least 30 days prior to the effective date of a new or renewed prepaid or managed care contract in a county.

(i) This section also applies to other Minnesota health care programs administered by the commissioner including, but not limited to, the MinnesotaCare program.

Sec. 49. Minnesota Statutes 2010, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; and

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15.

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

(g) For an eligible individual under the age of 65, in the absence of a specific managed care plan choice by the individual, the commissioner shall assign the individual to the county-based purchasing plan if any, in the county of the individual's residence. For an eligible individual over the age of 65, the commissioner shall make this default assignment

upon the county-based purchasing plan entering into a contract with the commissioner to serve this population and receiving federal approval as a special needs plan.

Sec. 50. Minnesota Statutes 2010, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

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

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

(c) A demonstration provider must accept into its medical assistance and MinnesotaCare provider networks any health care or social service provider that agrees to accept payment, quality assurance, and other contract terms that the demonstration provider applies to other similarly situated providers in its provider network.

EFFECTIVE DATE. This section is effective January 1, 2012, and applies to provider contracts that take effect on or after that date.

Sec. 51. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 30. **Provider payment rates.** (a) Each managed care and county-based plan shall, by October 1, 2011, array all providers, within each provider type, employed by or

under contract with the plan, by their average total annual cost of care for serving medical assistance and MinnesotaCare enrollees for the most recent reporting year for which data is available, risk-adjusted for enrollee demographics and health status.

(b) Beginning January 1, 2012, and each contract year thereafter, each managed care and county-based purchasing plan shall implement a progressive payment withhold methodology for each provider type, under which the withhold for a provider increases proportionally as the provider's risk-adjusted total annual cost increases, relative to other providers of the same type. For purposes of this paragraph, the risk-adjusted total annual cost of care is the dollar amount calculated under paragraph (a).

(c) At the end of each contract year, each plan shall array all providers, within each provider type, by their average total annual cost of care for serving medical assistance and MinnesotaCare enrollees for that contract year, risk adjusted for enrollee demographics and health status. For each provider whose risk-adjusted total annual cost of care is at or below a benchmark percentile established by the plan, the plan shall return the full amount of any withhold. For each provider whose risk-adjusted total annual cost of care is above the benchmark percentile, the plan shall return only that portion of the withhold sufficient to bring that provider's payment rate to the average for providers within the provider type whose risk-adjusted total annual cost of care is at the benchmark percentile. Each plan shall establish the benchmark percentile at a level which allows the plan to adjust expenditures for provider payments to reflect the reduction in capitation rates under paragraph (f).

(d) Each managed care and county-based purchasing plan must establish an appeals process to allow providers to appeal determinations of risk-adjusted total annual cost of care. Each plan's appeals process must be approved by the commissioner.

(e) The commissioner shall require each plan to submit to the commissioner, in the form and manner specified by the commissioner, all provider payment data and information on the withhold methodology that the commissioner determines is necessary to verify compliance with this subdivision.

(f) The commissioner, for the contract year beginning January 1, 2012, shall reduce plan capitation rates by 10 percent from the rates that would otherwise apply, absent application of this subdivision. This reduced rate shall be the historical base rate for negotiating capitation rates for future contract years. The commissioner may recommend additional reductions in capitation rates for future contract years to the legislature, if the commissioner determines this is necessary to ensure that health care providers under contract with managed care and county-based purchasing plans practice in an efficient manner.

(g) The commissioner of human services, in consultation with the commissioner of health, shall develop and provide to managed care and county-based purchasing plans, by September 1, 2011, standard criteria and definitions necessary for consistent calculation of the total annual risk-adjusted cost of care across plans. The commissioner may use encounter data collected under section 62U.04 to implement this subdivision, and may provide encounter data or analyses to plans. The provisions of section 62U.04, subdivision 4, paragraph (b), shall not apply to the commissioners of health and human services for purposes of this subdivision.

(h) For purposes of this subdivision, "provider" means a vendor of medical care as defined in section 256B.02, subdivision 7, for which sufficient encounter data on utilization and costs is available to implement this subdivision.

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

Sec. 52. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 30. **Initiatives to reduce incidence of low birth-weight.** The commissioner shall require managed care and county-based purchasing plans, as a condition of contract, to implement strategies to reduce the incidence of low birth-weight in geographic areas identified by the commissioner as having a higher than average incidence of low birth-weight, with special emphasis on areas within a one-mile radius of hospitals within their provider networks. These strategies may focus on smoking prevention and cessation, ensuring that pregnant women get adequate nutrition, and addressing demographic, social, and environmental risk factors. The strategies must coordinate health care with social services and the local public health system, and offer patient education through appropriate means. The commissioner shall require plans to submit proposed initiatives for approval to the commissioner by January 1, 2012, and the commissioner shall require plans to implement approved initiatives by July 1, 2012. The commissioner shall evaluate the strategies adopted to reduce low birth-weight, and shall require plans to submit outcome and other data necessary for the evaluation.

Sec. 53. Minnesota Statutes 2010, section 256B.692, subdivision 2, is amended to read:

Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. The county board of commissioners is the governing body of a county-based purchasing program. In a

multicounty arrangement, the governing body is a joint powers board established under section 471.59.

(b) A county that elects to purchase medical assistance services under this section must satisfy the commissioner of health that the requirements for assurance of consumer protection, provider protection, and, effective January 1, 2010, fiscal solvency of chapter 62D, applicable to health maintenance organizations will be met according to the following schedule:

(1) for a county-based purchasing plan approved on or before June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D as of January 1, 2010;

(ii) at least 75 percent of the minimum amount required under chapter 62D as of January 1, 2011;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D as of January 1, 2012; and

(iv) at least 100 percent of the minimum amount required under chapter 62D as of January 1, 2013; and

(2) for a county-based purchasing plan first approved after June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D at the time the plan begins enrolling enrollees;

(ii) at least 75 percent of the minimum amount required under chapter 62D after the first full calendar year;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D after the second full calendar year; and

(iv) at least 100 percent of the minimum amount required under chapter 62D after the third full calendar year.

(c) Until a plan is required to have reserves equaling at least 100 percent of the minimum amount required under chapter 62D, the plan may demonstrate its ability to cover any losses by satisfying the requirements of chapter 62N. Notwithstanding paragraphs (b) and (c), a county-based purchasing plan may satisfy its fiscal solvency requirements by obtaining written financial guarantees from participating counties in amounts equivalent to the minimum amounts that would otherwise apply. A county-based purchasing plan must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055; 62Q.106; 62Q.12; 62Q.135;

62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

(d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance services under this section.

(e) The commissioner, in consultation with county government, shall develop administrative and financial reporting requirements for county-based purchasing programs relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31, and other sections as necessary, that are specific to county administrative, accounting, and reporting systems and consistent with other statutory requirements of counties.

(f) The commissioner shall collect from a county-based purchasing plan under this section the following fees:

(1) fees attributable to the costs of audits and other examinations of plan financial operations. These fees are subject to the provisions of Minnesota Rules, part 4685.2800, subpart 1, item F;

(2) an annual fee of $21,500, to be paid by June 15 of each calendar year, beginning in calendar year 2009; and

(3) for fiscal year 2009 only, a per-enrollee fee of 14.6 cents, based on the number of enrollees as of December 31, 2008.

All fees collected under this paragraph shall be deposited in the state government special revenue fund.

Sec. 54. Minnesota Statutes 2010, section 256B.692, subdivision 5, is amended to read:

Subd. 5. **County proposals.** (a) On or before September 1, 1997, a county board that wishes to purchase or provide health care under this section must submit a preliminary proposal that substantially demonstrates the county's ability to meet all the requirements of this section in response to criteria for proposals issued by the department on or before July 1, 1997. Counties submitting preliminary proposals must establish a local planning process that involves input from medical assistance recipients, recipient advocates, providers and representatives of local school districts, labor, and tribal government to advise on the development of a final proposal and its implementation.

(b) The county board must submit a final proposal on or before July 1, 1998, that demonstrates the ability to meet all the requirements of this section, including beginning enrollment on January 1, 1999, unless a delay has been granted under section 256B.69, subdivision 3a, paragraph (g).

(c) After January 1, 1999, for a county in which the prepaid medical assistance program is in existence, the county board must submit a ~~preliminary proposal at least 15 months prior to termination of health plan contracts in that county and a final~~ proposal that meets the requirements of this section six months prior to the health plan contract termination date in order to begin enrollment after the termination. Nothing in this section shall impede or delay implementation or continuation of the prepaid medical assistance program in counties for which the board does not submit a proposal, or submits a proposal that is not in compliance with this section.

(d) The commissioner is not required to terminate contracts for the prepaid medical assistance program that begin on or after September 1, 1997, in a county for which a county board has submitted a proposal under this paragraph, until two years have elapsed from the date of initial enrollment in the prepaid medical assistance program.

Sec. 55. Minnesota Statutes 2010, section 256B.692, subdivision 7, is amended to read:

Subd. 7. **Dispute resolution.** In the event the commissioner rejects a proposal under subdivision 6, the county board may request the ~~recommendation~~ decision of a three-person mediation panel. The commissioner shall resolve all disputes ~~after taking into account~~ by following the ~~recommendations~~ decision of the mediation panel. The panel shall be composed of one designee of the president of the Association of Minnesota Counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

Sec. 56. Minnesota Statutes 2010, section 256B.692, is amended by adding a subdivision to read:

Subd. 11. **Patient choice of qualified provider.** Effective January 1, 2012, a county board operating a county-based purchasing plan must ensure that each enrollee has the option of choosing a primary care provider or a health care home from all qualified providers who agree to accept the terms, conditions, and payment rates offered by the plan to similarly situated providers. Notwithstanding this requirement, reimbursement to federally qualified health centers and federally qualified health center look-alikes as defined in section 145.9269 must be in compliance with federal law.

Sec. 57. Minnesota Statutes 2010, section 256B.694, is amended to read:

256B.694 SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE CONTRACT.

(a) Notwithstanding section 256B.692, subdivision 6, clause (1), paragraph (c), the commissioner of human services shall approve a county-based purchasing health plan proposal, submitted on behalf of Cass, Crow Wing, Morrison, Todd, and Wadena Counties, that requires county-based purchasing on a single-plan basis contract if the implementation of the single-plan purchasing proposal does not limit an enrollee's provider choice or access to services and all other requirements applicable to health plan purchasing are satisfied. The commissioner shall continue to use single-health plan, county-based purchasing arrangements for medical assistance and general assistance medical care programs and products for the counties that were in single-health plan, county-based purchasing arrangements on March 1, 2008. This paragraph does not require the commissioner to terminate an existing contract with a noncounty-based purchasing plan that had enrollment in a medical assistance program or product in these counties on March 1, 2008. This paragraph expires on December 31, 2010, or the effective date of a new contract for medical assistance and general assistance medical care managed care programs entered into at the conclusion of the commissioner's next scheduled reprocurement process for the county-based purchasing entities covered by this paragraph, whichever is later.

(b) At the request of a county or group of counties, the commissioner shall ~~consider, and may~~ approve~~,~~ contracting on a single-health plan basis with ~~other~~ county-based purchasing plans, or with other qualified health plans that have coordination arrangements with counties, to serve persons ~~with a disability who voluntarily enroll,~~ enrolled in Minnesota health care programs in order to promote better coordination or integration of health care services, social services and other community-based services, provided that all requirements applicable to health plan purchasing, including those in section 256B.69, subdivision 23, are satisfied. Nothing in this paragraph supersedes or modifies the requirements in paragraph (a).

Sec. 58. **[256B.7671] PATIENT-CENTERED DECISION-MAKING.**

(a) Effective January 1, 2012, the commissioner of human services shall require active participation in a patient-centered decision-making process before authorization is approved or payment reimbursement is provided for any of the following:

(1) a surgical procedure for the following conditions: abnormal uterine bleeding; benign prostate enlargement; chronic back pain; early stage of breast and prostate cancers;

gastroesophageal reflux disease; hemorrhoids; spinal stenosis; temporomandibular joint dysfunction; ulcerative colitis; urinary incontinence; uterine fibroids; or varicose veins; and

(2) bypass surgery for coronary disease; angioplasty for stable coronary artery disease; or total hip replacement.

(b) A list of these procedures shall be published in the State Register by October 1, 2011. The list shall be reviewed no less than every two years by the commissioner, in consultation with the commissioner of health. The commissioner shall hold a public forum and receive public comment prior to any changes to the list provided in paragraph (a). Any changes made shall be published in the State Register.

(c) Prior to receiving authorization or reimbursement for the procedures identified under this section, a health care provider must certify that the patient has participated in a patient-centered decision-making process. The format for this certification and the process for coordination between providers shall be developed by the Health Services Policy Committee under section 256B.0625, subdivision 3c.

(d) For purposes of this section, "patient-centered decision-making process" means a process that involves directed interaction with the patient to assist the patient in arriving at an informed objective health care decision regarding the surgical procedure that is both informed and consistent with the patient's preference and values. The interaction may be conducted by a health care provider or through the electronic use of decision aids. If decision aids are used in the process, the aids must meet the criteria established by the International Patients Decision Aids Standards Collaboration or the Cochrane Decision Aid Registry.

(e) This section does not apply if any of the procedures identified in this section are performed under an emergency situation.

Sec. 59. **[256B.771] COMPLEMENTARY AND ALTERNATIVE MEDICINE DEMONSTRATION PROJECT.**

Subdivision 1. **Establishment and implementation.** The commissioner of human services, in consultation with the commissioner of health, shall contract with a Minnesota-based academic and research institution specializing in providing complementary and alternative medicine education and clinical services to establish and implement a five-year demonstration project in conjunction with federally qualified health centers and federal qualified health center look-alikes as defined in section 145.9269, to improve the quality and cost-effectiveness of care provided under medical assistance to enrollees with neck and back problems. The demonstration project must maximize the use of complementary and alternative medicine-oriented primary care providers, including but

not limited to physicians and chiropractors. The demonstration project must be designed to significantly improve physical and mental health for enrollees who present with neck and back problems while decreasing medical treatment costs. The commissioner, in consultation with the commissioner of health, shall deliver services through the demonstration project beginning July 1, 2011, or upon federal approval, whichever is later.

Subd. 2. **RFP and project criteria.** The commissioner, in consultation with the commissioner of health, shall develop and issue an RFP for the demonstration project. The RFP must require the academic and research institution selected to demonstrate a proven track record over at least five years of conducting high quality, federally funded clinical research. The institution and the federally qualified health centers and federally qualified health center look-alikes shall also:

(1) provide patient education, provider education, and enrollment training components on health and lifestyle issues in order to promote enrollee responsibility for health care decisions, enhance productivity, prepare enrollees to reenter the workforce, and reduce future health care expenditures;

(2) use high-quality and cost-effective integrated disease management that includes the best practices of traditional and complementary and alternative medicine;

(3) incorporate holistic medical care, appropriate nutrition, exercise, medications, and conflict resolution techniques;

(4) include a provider education component that makes use of professional organizations representing chiropractors, nurses, and other primary care providers and provides appropriate educational materials and activities in order to improve the integration of traditional medical care with licensed chiropractic services and other alternative health care services and achieve program enrollment objectives; and

(5) provide to the commissioner the information and data necessary for the commissioner to prepare the annual reports required under subdivision 5.

Subd. 3. **Enrollment.** Enrollees from the program shall be selected by the commissioner from current enrollees in the prepaid medical assistance program who have, or are determined to be at significant risk of developing, neck and back problems. Participation in the demonstration project shall be voluntary. The commissioner shall seek to enroll, over the term of the demonstration project, ten percent of current and future medical assistance enrollees who have, or are determined to be at significant risk of developing, neck and back problems.

Subd. 4. **Federal approval.** The commissioner shall seek any federal waivers and approvals necessary to implement the demonstration project.

Subd. 5. **Project costs.** The commissioner shall require the academic and research institution selected, federally qualified health centers, and federally qualified health center look-alikes to fund all net costs of the demonstration project.

Subd. 6. **Annual reports.** The commissioner, in consultation with the commissioner of health, beginning December 15, 2011, and each December 15 thereafter through December 15, 2015, shall report annually to the legislature on the functional and mental improvements of the populations served by the demonstration project, patient satisfaction, and the cost-effectiveness of the program. The reports must also include data on hospital admissions, days in hospital, rates of outpatient surgery and other services, and drug utilization. The report due December 15, 2015, must include recommendations on whether the demonstration project should be continued and expanded.

Sec. 60. Minnesota Statutes 2010, section 256L.01, subdivision 4a, is amended to read:

Subd. 4a. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the ~~12-month~~ six-month period of eligibility using as a baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in depreciation, and carryover net operating loss amounts that apply to the business in which the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the ~~12-month~~ six-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year.

(c) "Gross individual or gross family income" means the total income for all family members, calculated for the ~~12-month~~ six-month period of eligibility.

Sec. 61. Minnesota Statutes 2010, section 256L.02, subdivision 3, is amended to read:

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, ~~and the Legislative Commission on Health Care Access,~~ the commissioner shall, as

necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

Sec. 62. Minnesota Statutes 2010, section 256L.03, subdivision 5, is amended to read:

Subd. 5. ~~**Co-payments and coinsurance**~~ **Cost-sharing.** (a) Except as provided in paragraphs (b) ~~and~~, (c), and (h), the MinnesotaCare benefit plan shall include the following ~~co-payments and coinsurance~~ cost-sharing requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual;

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist; ~~and~~

(5) $6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and $3.50 effective January 1, 2011; and

(6) a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21.

(c) Paragraph (a) does not apply to pregnant women and children under the age of 21.

(d) Paragraph (a), clause (4), does not apply to mental health services.

(e) Adult enrollees with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the $10,000 inpatient hospital benefit limit.

(f) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the $10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

(g) MinnesotaCare reimbursements to fee-for-service providers and payments to managed care plans or county-based purchasing plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause (5), effective January 1, 2011.

(h) Effective January 1, 2012, the following co-payments for nonpreventive visits shall apply to enrollees who are adults without children eligible under section 256L.04, subdivision 7:

(1) $3 for visits to providers whose average, risk-adjusted, total annual cost of care per MinnesotaCare enrollee is at the 60th percentile or lower for providers of the same type;

(2) $6 for visits to providers whose average, risk-adjusted, total annual cost of care per MinnesotaCare enrollee is greater than the 60th percentile but does not exceed the 80th percentile for providers of the same type; and

(3) $10 for visits to providers whose average, risk-adjusted, total annual cost of care per MinnesotaCare enrollee is greater than the 80th percentile for providers of the same type.

Each managed care and county based purchasing plan shall calculate the average, risk-adjusted, total annual cost of care for providers under this paragraph, using a methodology that has been approved by the commissioner.

Sec. 63. Minnesota Statutes 2010, section 256L.05, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) The commissioner or county agency shall use electronic verification as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual

may be required to submit additional verification. In addition, the commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the Department of Revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the MinnesotaCare program.

(b) In determining eligibility for MinnesotaCare, the commissioner shall require applicants and enrollees seeking renewal of eligibility to verify both earned and unearned income. The commissioner shall also require applicants and enrollees to submit the names of their employers and a contact name with a phone number for each employer for purposes of verifying whether the applicant or enrollee, and any dependents, are eligible for employer-subsidized coverage. Data collected is nonpublic data as defined in section 13.02, subdivision 9.

Sec. 64. Minnesota Statutes 2010, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, ~~2007~~ 2011, an enrollee's eligibility must be renewed every ~~12~~ six months. ~~The 12-month period begins in the month after the month the application is approved.~~

(b) The first six-month period of eligibility begins the month the application is received by the commissioner. The effective date of coverage within the first six-month period of eligibility is as provided in subdivision 3. Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. If there is no change in circumstances, the enrollee may renew eligibility at designated locations that include community clinics and health care providers' offices. The designated sites shall forward the renewal forms to the commissioner. The commissioner may establish criteria and timelines for sites to forward applications to the commissioner or county agencies. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) An enrollee who fails to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible for one additional month beyond the end of the current eligibility period before being disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the additional month.

Sec. 65. Minnesota Statutes 2010, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or 250 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(b) Notwithstanding paragraph (a), children may remain enrolled in MinnesotaCare if ten percent of their gross individual or gross family income as defined in section 256L.01, subdivision 4, is less than the ~~annual~~ premium for a six-month policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this clause shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(c) Notwithstanding paragraphs (a) and (b), parents are not eligible for MinnesotaCare if gross household income exceeds ~~$57,500 for the 12-month~~ $25,000 for the six-month period of eligibility.

Sec. 66. Minnesota Statutes 2010, section 256L.09, subdivision 4, is amended to read:

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

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

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

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

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

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

Sec. 67. Minnesota Statutes 2010, section 256L.15, subdivision 1a, is amended to read:

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

(1) payment by check;

(2) payment by credit card;

(3) payment by recurring automatic checking withdrawal;

(4) payment by onetime electronic transfer of funds;

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

(6) payment by using state tax refund payments.

The commissioner shall include information about these payment options on each premium notice. At application or reapplication, a MinnesotaCare applicant or enrollee may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to collect funds from the applicant's or enrollee's refund for the purposes of meeting all or

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

Sec. 68. Minnesota Statutes 2010, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. Until June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) Children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

(c) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d) with the exception that children in families with income at or below 150 percent of the federal poverty guidelines shall pay a monthly

premium of $4, and the commissioner shall increase premiums calculated under paragraph (d) by ten percent for adults without children eligible under section 256L.04, subdivision 7. For purposes of paragraph (d), "minimum" means a monthly premium of $4.

(d) The following premium scale is established for individuals and families with gross family incomes of 300 percent of the federal poverty guidelines or less:

Federal Poverty Guideline Range	**Percent of Average Gross Monthly Income**
0-45%	minimum
46-54%	1.1%
55-81%	1.6%
82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
165-191%	4.6%
192-219%	5.6%
220-248%	6.5%
249-274%	7.2%
275-300%	8.0%

Sec. 69. **PLAN TO COORDINATE CARE FOR CHILDREN WITH HIGH-COST MENTAL HEALTH CONDITIONS.**

The commissioner of human services shall develop, and submit to the legislature by December 15, 2011, a plan to provide care coordination to medical assistance and MinnesotaCare enrollees who are children with high-cost mental health conditions. For purposes of this section, a child has a "high-cost mental health condition" if mental health and medical expenses over the past year totalled $100,000 or more. For purposes of this section, "care coordination" means: collaboration between an advanced practice nurse and primary care physicians and specialists to manage care; development of mental health management plans for recurrent mental health issues; oversight and coordination of all aspects of care in partnership with families; organization of medical, treatment, and therapy information into a summary of critical information; coordination and appropriate sequencing of evaluations and multiple appointments; information and assistance with accessing resources; and telephone triage for behavior or other problems.

Sec. 70. **DATA ON CLAIMS AND UTILIZATION.**

The commissioner, in consultation with the Health and Human Services Reform Committee, shall develop and provide to the legislature by December 15, 2009, a methodology and any draft legislation necessary to allow for the release, upon request, of

summary data as defined in Minnesota Statutes, section 13.02, subdivision 19, on claims and utilization for medical assistance, general assistance medical care, and MinnesotaCare enrollees at no charge to the University of Minnesota Medical School, the Mayo Medical School, Northwestern Health Sciences University, the Institute for Clinical Systems Improvement, and other research institutions, to conduct analyses of health care outcomes and treatment effectiveness, provided the research institutions do not release private or nonpublic data, or data for which dissemination is prohibited by law.

Sec. 71. **REDUCTION OF STATE-MANDATED ADMINISTRATIVE REPORTS.**

(a) The commissioner of management and budget shall convene a report reduction working group of persons designated by the commissioners of health, human services, and commerce to eliminate redundant, unnecessary, obsolete, and low-priority state-mandated administrative reports required of health plans and county-based purchasing plans that serve persons enrolled in Minnesota health care programs. The commissioner of management and budget and the report reduction working group shall develop a plan to oversee the report reduction activities of the individual state agencies and coordinate the activities of multiple state agencies to consolidate reports or eliminate redundant reports required by more than one state agency on the same or a similar topic.

(b) The commissioners of health, human services, and commerce shall reduce, eliminate or consolidate state-mandated reports according to the plan developed by the commissioner of management and budget through the report reduction working group. In addition to other report reduction actions the commissioners or the working group may undertake, the commissioners shall:

(1) collect encounter data, including provider payment data if collected, in a consolidated report provided to a single state agency, with the data collected by that state agency to be shared with other state agencies who need the data;

(2) collect only one provider network report annually through a single state agency, with the data collected by that state agency to be shared with other state agencies who need the data;

(3) collect only one standard financial report through a single state agency, with the data collected by that state agency to be shared with other state agencies who need the data. Data collected must be of a nature and in a format to allow comparison of the cost-effectiveness of fee-for-service payment systems and prepaid programs administered by health plans and county-based purchasing plans;

(4) consolidate and simplify reports and documentation requirements relating to member communications and marketing materials, and establish a single review process for all programs, products, and agencies in order to assure uniform and consistent regulation of health plan contracts;

(5) consolidate state regulation and oversight of health plans and county-based purchasing plans so that activities of multiple agencies are administered through an efficient and uniform multiagency process of oversight and audits, with consistent standards, measures, and definitions for state oversight of quality, utilization management, care management, delegation accountability, access to care, appeals and grievances, and financial management;

(6) establish uniform requirements and procedures for denial, termination, or reduction of services, and member appeals and grievances, and align state requirements and procedures with federal requirements and procedures;

(7) reform the state's performance improvement projects, requirements, and procedures to be more flexible and efficient, and to place greater focus on measuring improvement of outcomes and less on mandating detailed or prescriptive requirements for specific performance improvement projects or activities;

(8) new reporting requirements or ad hoc report requests shall be established by a state agency only:

(i) if required by a federal agency;

(ii) if needed for a state regulatory audit or corrective action plan; or

(iii) after the completion of a review and analysis, and the development of recommendations by the commissioner of management and budget, in consultation with the report reduction working group, regarding the necessity, importance, and administrative cost of the new report, and after completing a review to determine whether the information sought can be obtained through another available state or federal report. The results of the review, analysis and recommendations of the commissioner of management and budget must be provided to health plans and county-based purchasing plans for review and comment at least 60 days before a new report or requirement is established; and

(9) to the extent possible, all state agencies shall use the procedures, reports, and audits of the Centers for Medicare and Medicaid Services instead of requiring an additional state-mandated report on the same or a similar topic.

(c) By January 15, 2012, the commissioner of management and budget shall provide a report on the activities and results of the report reduction project to the chairs and ranking minority members of the legislative committees of the house and senate

with jurisdiction over health plan or county-based purchasing payment, regulation, and performance. The report must include:

(1) a timetable for report reduction actions already taken or planned by the commissioners or the report reduction working group;

(2) the specific reports that have been or will be eliminated or consolidated;

(3) the amount of money that will be saved through reductions in administrative costs of health plans and county-based purchasing plans as a result of the report reduction project; and

(4) proposed legislation for changes to laws or rules that are needed to allow state agencies to further reduce, consolidate, or eliminate reports when the changes cannot be made administratively.

Sec. 72. **PATIENT AND COMMUNITY ENGAGEMENT IN PAYMENT REFORM AND HEALTH CARE PROGRAM REFORMS.**

Subdivision 1. **Implementation of data system improvements.** The commissioners of health and human services shall implement the recommendations regarding data on health disparities that were contained in the report prepared under Minnesota Laws 2010, First Special Session, chapter 1, article 19, section 23, in consultation with an advisory work group representing racial and ethnic groups and representatives of government and private sector health care organizations. Among other activities, the commissioners shall: continue engagement with diverse communities on collection of and access to racial and ethnic data from state agencies, health care providers, and health plans; develop a plan to make data more accessible to communities; develop consistent data elements across programs when feasible; and develop consistent policies on data sampling.

Subd. 2. **Patient and community engagement.** The commissioner of health, in cooperation with the commissioners of human services and commerce, shall consult with an advisory committee representing racial and ethnic groups, regarding the implementation of subdivision 1 and major agency activities related to state and federal health care reform, payment reform demonstration projects, state health care program reforms, improvements in quality and patient satisfaction measures, and major changes in state public health priorities and strategies. At the request of the advisory committee established under Minnesota Laws 2010, First Special Session, chapter 1, article 19, section 23, the commissioner shall designate a private sector organization of multiple racial and ethnic groups to serve as the advisory committee under this subdivision.

Sec. 73. **REQUEST FOR PROPOSAL; PROVIDER BILLING PATTERNS.**

(a) The commissioner of human services shall issue a request for proposal to identify abnormal provider billing patterns in order to prevent and identify improper medical assistance payments.

(b) The request for proposal must include the following requirements for the contractor:

(1) identification and reporting of improper claims, outlier claims, and improper payments, both prior to and subsequent to reimbursement;

(2) utilization of fraud detection methods that maximize contemporary predictive analytic tools, including but not limited to identity analytics, link analysis, and matching capabilities;

(3) utilization of data analytics that improve fraud detection through the identification of outlier reimbursement;

(4) reduction in state expenditures by reducing or eliminating payouts of improper medical assistance claims; and

(5) demonstrated success with other states and state agencies using the specified proposed solution, deployment, and implementation.

(c) The commissioner shall enter into a contract for these services by October 1, 2011. The contract must incorporate a performance-based vendor financing mechanism under which the vendor shares in the risk of the project's success.

Sec. 74. **HEALTH SERVICES POLICY COMMITTEE STUDIES.**

(a) The commissioner, through health services policy committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall identify and review medical assistance services provided by health care professionals who are not trained to provide the services in a high-quality manner. The commissioner shall develop a process to limit payment for medical assistance services to providers who are appropriately trained to provide the service, and shall present recommendations and draft legislation, by January 15, 2012, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

(b) The commissioner, through health services policy committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall study the effectiveness of new strategies for wound care treatment for medical assistance and MinnesotaCare enrollees with diabetes, including but not limited to the use of new wound care technologies, assessment tools, and reporting programs. The commissioner shall present recommendations by December 15, 2011, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and

finance, on whether these new strategies for wound care treatment should be covered under medical assistance and MinnesotaCare.

Sec. 75. **SPECIALIZED MAINTENANCE THERAPY.**

The commissioner of human services shall evaluate whether providing medical assistance coverage for specialized maintenance therapy for enrollees with serious and persistent mental illness who are at risk of hospitalization will improve the quality of care and lower medical assistance spending by reducing rates of hospitalization. The commissioner shall present findings and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy, by December 15, 2011.

Sec. 76. **ADVISORY COMMITTEE ON PATIENT AND COMMUNITY ENGAGEMENT.**

$..... is appropriated to the commissioner of health to provide a grant to a private sector organization designated as the advisory committee on patient and community engagement under section 72 to be used by the organization for:

(1) per diems and expenses for persons who serve on the designated organization's board; and

(2) expenses for conducting focus groups, community engagement events, surveys, and other activities undertaken by the designated organization to obtain information, input and preferences from diverse communities for purposes of community engagement in health system issues under section 72.

Sec. 77. **STATE SUBSIDY PROGRAM FOR COMMUNITY MENTAL HEALTH CENTERS.**

$..... is appropriated from the general fund to the commissioner of human services for the biennium beginning July 1, 2011, to provide grants to establish new community mental health centers that are eligible for payment under Minnesota Statutes, section 256B.0625, subdivision 5. In awarding grants, the commissioner shall give preference to areas of the state that lack access to mental health services or are underserved.

Sec. 78. **INCREASE IN CARE COORDINATION PAYMENTS.**

$..... is appropriated from the general fund to the commissioner of human services for the biennium beginning July 1, 2011, to increase monthly care coordination payments

under Minnesota Statutes, section 256B.0753, that apply to each level of health care home by $50.

Sec. 79. **REPEALER.**

Subdivision 1. **Performance payments.** Minnesota Statutes 2010, section 256.01, subdivision 2b, is repealed effective July 1, 2011.

Subd. 2. **Legislative Commission on Health Care Access.** Minnesota Statutes 2010, section 62J.07, subdivisions 1, 2, and 3, are repealed.

Subd. 3. **Exemption of low-income children from MinnesotaCare premiums and insurance barriers.** Laws 2009, chapter 79, article 5, sections 64 (256L.07, subdivision 2); 65 (256L.07, subdivision 3); and 68 (256L.15, subdivision 2), are repealed retroactively from July 1, 2009, and federal approval is no longer necessary.