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460.12 **ARTICLE 25**
460.13 **HEALTH CARE**

460.14 Section 1. Minnesota Statutes 2015 Supplement, section 16A.724, subdivision 2,
460.15 is amended to read:

460.16 Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available
460.17 resources in the health care access fund exceed expenditures in that fund, effective for
460.18 the biennium beginning July 1, 2007, the commissioner of management and budget
460.19 shall transfer the excess funds from the health care access fund to the general fund on
460.20 June 30 of each year, provided that the amount transferred in fiscal year 2016 shall not
460.21 exceed $48,000,000, the amount in fiscal year 2017 shall not exceed $122,000,000, and
460.22 the amount in any fiscal biennium thereafter shall not exceed ~~$96,000,000~~ $244,000,000.
460.23 The purpose of this transfer is to meet the rate increase required under Laws 2003, First
460.24 Special Session chapter 14, article 13C, section 2, subdivision 6.

460.25 (b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and,
460.26 if necessary, the commissioner shall reduce these transfers from the health care access
460.27 fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary,
460.28 transfer sufficient funds from the general fund to the health care access fund to meet
460.29 annual MinnesotaCare expenditures.

20.1 **ARTICLE 2**
20.2 **HEALTH CARE**
32.21 **ARTICLE 3**
32.22 **MNSURE**

32.23 Section 1. **[45.0131] LEGISLATIVE ENACTMENT REQUIRED.**

32.24 Subdivision 1. **Agency agreements.** The commissioner of commerce shall not
32.25 enter into or renew any interagency agreement or service level agreement with a value of
32.26 more than $100,000 a year, or related agreements with a cumulative value of more than
32.27 $100,000 a year, with a state department, state agency, or the Office of MN.IT Services,
32.28 unless the specific agreement is authorized by enactment of a new law. If an agreement,
32.29 including an agreement in effect as of the effective date of this section, does not have a
32.30 specific expiration date, the agreement shall expire two years from the effective date of
32.31 this section or the effective date of the agreement, whichever is later, unless the specific
32.32 agreement is authorized by enactment of a new law.

33.1 Subd. 2. **Transfers.** Notwithstanding section 16A.285, the commissioner shall not
33.2 transfer appropriations and funds in amounts over $100,000 across agency accounts or
33.3 programs, unless the specific transfer is authorized by enactment of a new law.

33.4 Subd. 3. **Definitions.** For purposes of this section, "state department" has the
33.5 meaning provided in section 15.01, and "state agency" has the meaning provided in
33.6 section 15.012.

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

460.30 Sec. 2. Minnesota Statutes 2014, section 62J.497, subdivision 1, is amended to read:

461.1 Subdivision 1. **Definitions.** For the purposes of this section, the following terms
461.2 have the meanings given.

461.3 (a) "Backward compatible" means that the newer version of a data transmission
461.4 standard would retain, at a minimum, the full functionality of the versions previously
461.5 adopted, and would permit the successful completion of the applicable transactions with
461.6 entities that continue to use the older versions.

461.7 (b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision
461.8 30. Dispensing does not include the direct administering of a controlled substance to a
461.9 patient by a licensed health care professional.

461.10 (c) "Dispenser" means a person authorized by law to dispense a controlled substance,
461.11 pursuant to a valid prescription.

461.12 (d) "Electronic media" has the meaning given under Code of Federal Regulations,
461.13 title 45, part 160.103.

461.14 (e) "E-prescribing" means the transmission using electronic media of prescription
461.15 or prescription-related information between a prescriber, dispenser, pharmacy benefit
461.16 manager, or group purchaser, either directly or through an intermediary, including
461.17 an e-prescribing network. E-prescribing includes, but is not limited to, two-way
461.18 transmissions between the point of care and the dispenser and two-way transmissions
461.19 related to eligibility, formulary, and medication history information.

461.20 (f) "Electronic prescription drug program" means a program that provides for
461.21 e-prescribing.

461.22 (g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

461.23 (h) "HL7 messages" means a standard approved by the standards development
461.24 organization known as Health Level Seven.

461.25 (i) "National Provider Identifier" or "NPI" means the identifier described under Code
461.26 of Federal Regulations, title 45, part 162.406.

461.27 (j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

461.28 (k) "NCPDP Formulary and Benefits Standard" means the National Council for
461.29 Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide,
461.30 Version 1, Release 0, October 2005.

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(l) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.

(m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(n) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

(o) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(p) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

(q) "Utilization review organization" has the meaning given in section 62M.02, subdivision 21.

Sec. 3. Minnesota Statutes 2014, section 62J.497, subdivision 3, is amended to read:

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. The NCPDP SCRIPT Standard shall be used to conduct the following transactions:

(1) get message transaction;

(2) status response transaction;

(3) error response transaction;

(4) new prescription transaction;

(5) prescription change request transaction;

(6) prescription change response transaction;

(7) refill prescription request transaction;

(8) refill prescription response transaction;

(9) verification transaction;

(10) password change transaction;

(11) cancel prescription request transaction; and

(12) cancel prescription response transaction.

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Group purchaser, other than workers' compensation plans and the medical component of automobile insurance coverage, and utilization review organizations must develop processes to ensure that prescribers can obtain information about covered drugs from the same class or classes as a drug originally prescribed but denied. This process must allow communication to the prescriber via telephone, or for the medical assistance fee-for-service program under chapter 256B via a public Web site.

~~(d)~~ (e) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

~~(e)~~ (f) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

Sec. 4. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 10a. **Drug.** "Drug" has the meaning given in section 151.01, subdivision 5.

Sec. 5. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 11a. **Formulary.** "Formulary" has the meaning given in section 62Q.83, subdivision 1.

Sec. 6. Minnesota Statutes 2014, section 62M.02, subdivision 12, is amended to read:

Subd. 12. **Health benefit plan.** "Health benefit plan" means a policy, contract, or certificate issued by a health plan company for the coverage of medical, dental, prescription drug, or hospital benefits. A health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis;

(5) credit accident and health insurance issued under chapter 62B;

(6) blanket accident and sickness insurance as defined in section 62A.11;

(7) accident only coverage issued by a licensed and tested insurance agent; or

(8) workers' compensation.

Sec. 7. Minnesota Statutes 2014, section 62M.02, subdivision 14, is amended to read:

Subd. 14. **Outpatient services.** "Outpatient services" means procedures or services performed on a basis other than as an inpatient, and includes obstetrical, psychiatric, chemical dependency, dental, prescription drug, and chiropractic services.

Sec. 8. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 14a. **Prescription.** "Prescription" has the meaning given in section 151.01, subdivision 16a.

Sec. 9. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 14b. **Prescription drug order.** "Prescription drug order" has the meaning given in section 151.01, subdivision 16.

Sec. 10. Minnesota Statutes 2014, section 62M.02, subdivision 15, is amended to read:

Subd. 15. **Prior authorization.** "Prior authorization" means utilization review conducted prior to the delivery of a service, including an outpatient service. Prior authorization includes, but is not limited to, preadmission review, pretreatment review, quantity limits, step therapy, utilization, and case management. Prior authorization also includes any utilization review organization's requirement that an enrollee or provider notify the utilization review organization prior to providing a service, including an outpatient service. Reviews performed for emergency medical assistance benefits, medical assistance waivered services, or the Minnesota restricted recipient program are not prior authorization.

Sec. 11. Minnesota Statutes 2014, section 62M.02, subdivision 17, is amended to read:

Subd. 17. **Provider.** "Provider" means a licensed health care facility, physician, pharmacist, or other health care professional that delivers health care services to an enrollee.

Sec. 12. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 18a. **Quantity limit.** "Quantity limit" means a limit on the number of doses of a prescription drug that are covered during a specific time period.

Sec. 13. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 19a. **Step therapy.** "Step therapy" means clinical practice or other evidence-based protocols or requirements that specify the sequence in which different prescription drugs for a given medical condition are to be used by an enrollee before a drug prescribed by a provider is covered. Step therapy does not include a requirement for an enrollee to use a generic or biosimilar product considered by the Food and Drug Administration to be therapeutically equivalent and interchangeable to a branded product, provided the generic or biosimilar product has not previously been tried by the patient.

Sec. 14. Minnesota Statutes 2014, section 62M.05, subdivision 3a, is amended to read:

Subd. 3a. **Standard review determination.** (a) Notwithstanding subdivision 3b, an initial determination on all requests for utilization review, except a determination related to prescription drugs, must be communicated to the provider and enrollee in accordance with this subdivision within ten business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) An initial determination for utilization review on all prescription drug requests must be communicated to the provider and enrollee in accordance with this subdivision within five business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

~~(b)~~ (c) When an initial determination is made to certify, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee; the service, procedure, or admission certified; and the date of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number." For purposes of this subdivision, notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. These electronic forms of notification satisfy the "audit trail" requirement of this paragraph.

~~(c)~~ (d) When an initial determination is made not to certify, notification must be provided by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox within one working day after making the determination to the attending health care professional and hospital as applicable. Written notification must also be sent to the hospital as applicable and attending health care professional if notification occurred by telephone. For purposes of this subdivision, notification may be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written notification must be sent to the enrollee and may be sent by United States mail, facsimile to a verified number, or by electronic mail to a secure mailbox. The written notification must include the principal reason or reasons for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the provider or enrollee.

~~(d)~~ (e) When an initial determination is made not to certify, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for initiating the internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

Sec. 15. Minnesota Statutes 2014, section 62M.05, subdivision 3b, is amended to read:

Subd. 3b. **Expedited review determination.** (a) An expedited initial determination must be utilized if the attending health care professional believes that an expedited determination is warranted.

(b) Notification of an expedited initial determination to either certify or not to certify, except a determination related to prescription drugs, must be provided to the hospital, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from the initial request. When an expedited initial determination is made not to certify, the utilization review organization must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal as described in section 62M.06 and the procedure for initiating an internal expedited appeal.

(c) Notification of an expedited initial determination to either certify or not to certify on all prescription drug requests must be provided to the hospital, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than 36 hours from the initial request, provided that all the information reasonably necessary to make a determination has been made available to the utilization review organization. For state public health care programs administered under section 256B.69 and chapter 256L, notification must be provided to the hospital, attending health care provider, or the enrollee as expeditiously as the enrollee's condition requires, but no later than 36 hours from the initial request, provided that all the information reasonably necessary to make a determination has been made available to the utilization review organization. When an expedited initial determination is made not to certify, the utilization review organization must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal as described in section 62M.06, and the procedure for initiating an internal expedited appeal.

Sec. 16. Minnesota Statutes 2014, section 62M.06, subdivision 2, is amended to read:

Subd. 2. **Expedited appeal.** (a) When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, the utilization review organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider.

(b) The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination, except for determinations related to prescription drugs, on the expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal. The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination on the expedited appeal of a prescription drug request as expeditiously as the enrollee's medical condition requires, but no later than 36 hours after receiving the expedited appeal.

(c) If the determination not to certify is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.

Sec. 17. Minnesota Statutes 2014, section 62M.06, subdivision 3, is amended to read:

Subd. 3. **Standard appeal.** The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

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(a) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal, except for determinations related to prescription drugs, within 30 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination within 30 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to 14 additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial 30-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

(b) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal on a prescription drug within 15 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination on a prescription drug within 15 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to ten additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial 15-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

~~(b)~~ (c) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care professional.

~~(c)~~ (d) Prior to upholding the initial determination not to certify for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the initial determination not to certify.

~~(d)~~ (e) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the enrollee and attending health care professional when the initial determination is made.

~~(e)~~ (f) An attending health care professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

~~(f)~~ (g) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must ensure that a physician of the utilization review organization's choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

~~(g)~~ (h) If the initial determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating the external process.

Sec. 18. Minnesota Statutes 2014, section 62M.07, is amended to read:

62M.07 PRIOR AUTHORIZATION OF SERVICES.

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section 62M.05, subdivisions 3a and 3b, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible.

(c) If prior authorization for a health care service is required, the utilization review organization, health plan company, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, seven days a week. This paragraph does not apply to dental service covered under MinnesotaCare, general assistance medical care, or medical assistance.

(d) Any authorization for a prescription drug must remain valid for the duration of an enrollee's contract term, or for the benefits offered under section 256B.69 or chapter 256L, for the duration of the enrollee's enrollment or one year, whichever is shorter, provided: the drug continues to be prescribed for a patient with a condition that requires ongoing medication therapy; the drug has not otherwise been deemed unsafe by the Food and Drug Administration; the drug has not been withdrawn by the manufacturer or the Food and Drug Administration; there is no evidence of the enrollee's abuse or misuse of the prescription drug; or no independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage. This paragraph does not apply to individuals assigned to the restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

(e) No utilization review organization, health plan company, or claims administrator may impose step therapy requirements for the following drug classes:

(1) immunosuppressants;

(2) antidepressants;

(3) antipsychotics;

(4) anticonvulsants;

(5) antiretrovirals; or

(6) antineoplastics.

(f) No utilization review organization, health plan company, or claims administrator may impose step therapy requirements for enrollees currently taking a prescription drug for which the patient satisfied a previous step therapy requirement, as substantiated from available claims data or provider documentation. This provision does not apply to a patient who has initiated treatment for a condition with samples provided by a prescriber and provided that any step therapy requirements subsequently applied are consistent with evidence-based prescribing practices.

Sec. 19. Minnesota Statutes 2014, section 62M.09, subdivision 3, is amended to read:

Subd. 3. **Physician reviewer involvement.** (a) A physician must review all cases in which the utilization review organization has concluded that a determination not to certify for clinical reasons is appropriate.

(b) The physician conducting the review must be licensed in this state. ~~This paragraph does not apply to reviews conducted in connection with policies issued by a health plan company that is assessed less than three percent of the total amount assessed by the Minnesota Comprehensive Health Association.~~

(c) The physician should be reasonably available by telephone to discuss the determination with the attending health care professional.

(d) This subdivision does not apply to outpatient mental health or substance abuse services governed by subdivision 3a.

Sec. 20. Minnesota Statutes 2014, section 62M.11, is amended to read:

62M.11 COMPLAINTS TO COMMERCE OR HEALTH.

Notwithstanding the provisions of sections 62M.01 to 62M.16, an enrollee or provider may file a complaint regarding compliance with the requirements of this chapter or regarding a determination not to certify directly to the commissioner responsible for regulating the utilization review organization.

Sec. 21. Minnesota Statutes 2014, section 62Q.81, subdivision 4, is amended to read:

Subd. 4. **Essential health benefits; definition.** For purposes of this section, "essential health benefits" has the meaning given under section 1302(b) of the Affordable Care Act and includes:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) laboratory services;

(5) maternity and newborn care;

(6) mental health and substance use disorder services, including behavioral health treatment;

(7) pediatric services, including oral and vision care;

(8) prescription drugs;

(9) preventive and wellness services and chronic disease management;

(10) rehabilitative and habilitative services and devices, including services for autism spectrum disorder treatment specified pursuant to section 62A.3094; and

(11) additional essential health benefits included in the EHB-benchmark plan, as defined under the Affordable Care Act.

EFFECTIVE DATE. This section is effective upon a formal determination from the Centers of Medicare and Medicaid Services that the inclusion of the autism spectrum disorder treatment services under Minnesota Statutes, section 62Q.81, subdivision 4, clause (10), as a rehabilitative and habilitative service is not a new state mandate and the state is not required to cover the cost for the services described under Minnesota Statutes, section 62A.3094. Upon a formal determination, this section is effective for health plans issued or renewed on or after January 1 of the next coverage year.

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Sec. 22. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Enrollee contract year" means the 12-month term during which benefits associated with health plan company products are in effect. For managed care plans and county-based purchasing plans under section 256B.69 and chapter 256L, it means a calendar year beginning January through December.

(d) "Formulary" means a list of prescription drugs that have been developed by clinical and pharmacy experts and represents the health plan company's medically appropriate and cost-effective prescription drugs approved for use.

(e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and includes an entity that performs pharmacy benefits management for the health plan company. For purposes of this definition, "pharmacy benefits management" means the administration or management of prescription drug benefits provided by the health plan company for the benefit of its enrollees and may include, but is not limited to, procurement of prescription drugs, clinical formulary development and management services, claims processing, and rebate contracting and administration.

(f) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides prescription drug benefit coverage and uses a formulary must make its formulary and related benefit information available by electronic means and, upon request, in writing, at least 30 days prior to annual renewal dates.

(b) Formularies must be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's (USP) Model Guidelines.

(c) For each item or category of items on the formulary, the specific enrollee benefit terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan company may, at any time during the enrollee's contract year:

(1) expand its formulary by adding drugs to the formulary;

(2) reduce co-payments or coinsurance; or

(3) move a drug to a benefit category that reduces an enrollee's cost.

(b) A health plan company may remove a brand name drug from its formulary or place a brand name drug in a benefit category that increases an enrollee's cost only upon the addition to the formulary of a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book or a biologic drug rated as interchangeable according to the FDA Purple Book, at a lower cost to the enrollee, and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

(c) A health plan company may change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the enrollee's contract year upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided that these changes do not apply to enrollees who are currently taking the drugs affected by these changes for the duration of the enrollee's contract year.

(d) A health plan company may remove any drugs from its formulary that have been deemed unsafe by the Food and Drug Administration, that have been withdrawn by either the Food and Drug Administration or the product manufacturer, or where an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

Subd. 4. **Transition process.** (a) A health plan company must establish and maintain a transition process to prevent gaps in prescription drug coverage for both new and continuing enrollees with ongoing prescription drug needs who are affected by changes in formulary drug availability.

(b) The transition process must provide coverage for at least 60 days.

(c) Any enrollee cost-sharing applied must be based on the defined prescription drug benefit terms and must be consistent with any cost-sharing that the health plan company would charge for nonformulary drugs approved under a medication exceptions process.

(d) A health plan company must ensure that written notice is provided to each affected enrollee and prescriber within three business days after adjudication of the transition coverage.

Subd. 5. **Medication exceptions process.** (a) Each health plan company must establish and maintain a medication exceptions process that allows enrollees, providers, or an enrollee's authorized representative to request and obtain coverage approval in the following situations:

(1) there is no acceptable clinical alternative listed on the formulary to treat the enrollee's disease or medical condition;

(2) the prescription listed on the formulary has been ineffective in the treatment of an enrollee's disease or medical condition or, based on clinical and scientific evidence and the relevant physical or mental characteristics of the enrollee, is likely to be ineffective or adversely affect the drug's effectiveness or the enrollee's medication compliance; or

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(3) the number of doses that are available under a dose restriction has been ineffective in the treatment of the enrollee's disease or medical condition or, based on clinical and scientific evidence and the relevant physical or mental characteristics of the enrollee, is likely to be ineffective or adversely affect the drug's effectiveness or the enrollee's medication compliance.

(b) An approved medication exceptions request must remain valid for the duration of an enrollee's contract term, provided the medication continues to be prescribed for the same condition, and provided the medication has not otherwise been withdrawn by the manufacturer or the Food and Drug Administration.

(c) The medication exceptions process must comply with the requirements of chapter 62M.

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Sec. 2. Minnesota Statutes 2015 Supplement, section 62V.03, subdivision 2, is amended to read:

Subd. 2. **Application of other law.** (a) MNsure must be reviewed by the legislative auditor under section 3.971. The legislative auditor shall audit the books, accounts, and affairs of MNsure once each year or less frequently as the legislative auditor's funds and personnel permit. Upon the audit of the financial accounts and affairs of MNsure, MNsure is liable to the state for the total cost and expenses of the audit, including the salaries paid to the examiners while actually engaged in making the examination. The legislative auditor may bill MNsure either monthly or at the completion of the audit. All collections received for the audits must be deposited in the general fund and are appropriated to the legislative auditor. Pursuant to section 3.97, subdivision 3a, the Legislative Audit Commission is requested to direct the legislative auditor to report by March 1, 2014, to the legislature on any duplication of services that occurs within state government as a result of the creation of MNsure. The legislative auditor may make recommendations on consolidating or eliminating any services deemed duplicative. The board shall reimburse the legislative auditor for any costs incurred in the creation of this report.

(b) Board members of MNsure are subject to sections 10A.07 and 10A.09. Board members and the personnel of MNsure are subject to section 10A.071.

(c) All meetings of the board and of the Minnesota Eligibility System Executive Steering Committee established under section 62V.056 shall comply with the open meeting law in chapter 13D.

(d) The board and the Web site are exempt from chapter 60K. Any employee of MNsure who sells, solicits, or negotiates insurance to individuals or small employers must be licensed as an insurance producer under chapter 60K.

(e) Section 3.3005 applies to any federal funds received by MNsure.

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(f) A MNsure decision that requires a vote of the board, other than a decision that applies only to hiring of employees or other internal management of MNsure, is an "administrative action" under section 10A.01, subdivision 2.

Sec. 3. Minnesota Statutes 2014, section 62V.04, subdivision 2, is amended to read:

Subd. 2. **Appointment.** (a) Board membership of MNsure consists of the following:

(1) three members appointed by the governor with the advice and consent of both the senate and the house of representatives acting separately in accordance with paragraph (d), with one member representing the interests of individual consumers eligible for individual market coverage, one member representing individual consumers eligible for public health care program coverage, and one member representing small employers. Members are appointed to serve four-year terms following the initial staggered-term lot determination;

(2) three members appointed by the governor with the advice and consent of both the senate and the house of representatives acting separately in accordance with paragraph (d) who have demonstrated expertise, leadership, and innovation in the following areas: one member representing the areas of health administration, health care finance, health plan purchasing, and health care delivery systems; one member representing the areas of public health, health disparities, public health care programs, and the uninsured; and one member representing health policy issues related to the small group and individual markets. Members are appointed to serve four-year terms following the initial staggered-term lot determination; and

(3) ~~the commissioner of human services or a designee~~ one member representing the interests of the general public, appointed by the governor with the advice and consent of both the senate and the house of representatives acting in accordance with paragraph (d). A member appointed under this clause shall serve a four-year term.

(b) Section 15.0597 shall apply to all appointments~~, except for the commissioner~~.

(c) The governor shall make appointments to the board that are consistent with federal law and regulations regarding its composition and structure. All board members appointed by the governor must be legal residents of Minnesota.

(d) Upon appointment by the governor, a board member shall exercise duties of office immediately. If both the house of representatives and the senate vote not to confirm an appointment, the appointment terminates on the day following the vote not to confirm in the second body to vote.

(e) Initial appointments shall be made by April 30, 2013.

(f) One of the six members appointed under paragraph (a), clause (1) or (2), must have experience in representing the needs of vulnerable populations and persons with disabilities.

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(g) Membership on the board must include representation from outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

Sec. 4. Minnesota Statutes 2014, section 62V.04, subdivision 3, is amended to read:

Subd. 3. **Terms.** (a) Board members may serve no more than two consecutive terms~~, except for the commissioner or the commissioner's designee, who shall serve until replaced by the governor~~.

(b) A board member may resign at any time by giving written notice to the board.

(c) The appointed members under subdivision 2, paragraph (a), clauses (1) and (2), shall have an initial term of two, three, or four years, determined by lot by the secretary of state.

Sec. 5. Minnesota Statutes 2014, section 62V.04, subdivision 4, is amended to read:

Subd. 4. **Conflicts of interest.** (a) Within one year prior to or at any time during their appointed term, board members appointed under subdivision 2, paragraph (a), ~~clauses (1) and (2),~~ shall not be employed by, be a member of the board of directors of, or otherwise be a representative of a health carrier, institutional health care provider or other entity providing health care, navigator, insurance producer, or other entity in the business of selling items or services of significant value to or through MNsure. For purposes of this paragraph, "health care provider or entity" does not include an academic institution.

(b) Board members must recuse themselves from discussion of and voting on an official matter if the board member has a conflict of interest. A conflict of interest means an association including a financial or personal association that has the potential to bias or have the appearance of biasing a board member's decisions in matters related to MNsure or the conduct of activities under this chapter.

(c) No board member shall have a spouse who is an executive of a health carrier.

(d) No member of the board may currently serve as a lobbyist, as defined under section 10A.01, subdivision 21.

Sec. 23. **[62V.041] GOVERNANCE OF THE SHARED ELIGIBILITY SYSTEM.**

Subdivision 1. **Definition; shared eligibility system.** "Shared eligibility system" means the system that supports eligibility determinations using a modified adjusted gross income methodology for medical assistance under section 256B.056, subdivision 1a, paragraph (b), clause (1); MinnesotaCare under chapter 256L; and qualified health plan enrollment under section 62V.05, subdivision 5, paragraph (c).

Sec. 10. **[62V.056] MINNESOTA ELIGIBILITY SYSTEM EXECUTIVE STEERING COMMITTEE.**

Subdivision 1. **Definition; Minnesota eligibility system.** For purposes of this section, "Minnesota eligibility system" means the system that supports eligibility determinations using a modified adjusted gross income methodology for medical assistance under section 256B.056, subdivision 1a, paragraph (b), clause (1); MinnesotaCare under chapter 256L; and qualified health plan enrollment under section 62V.05, subdivision 5, paragraph (c).

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Subd. 2. **Executive steering committee.** The shared eligibility system shall be governed and administered by a seven-member executive steering committee. The steering committee shall consist of two members appointed by the commissioner of human services, two members appointed by the board, two members appointed by the commissioner of MN.IT, and one county representative appointed by the commissioner of human services. The commissioner of human services shall designate one of the members appointed by the commissioner of human services to serve as chair of the steering committee.

Subd. 3. **Duties.** (a) The steering committee shall establish an overall governance structure for the shared eligibility system, and shall be responsible for the overall governance of the system, including setting goals and priorities, allocating the system's resources, and making major system decisions.

(b) The steering committee shall adopt bylaws, policies, and interagency agreements necessary to administer the shared eligibility system.

Subd. 4. **Decision making.** The steering committee, to the extent feasible, shall operate under a consensus model. The steering committee shall make decisions that give particular attention to parts of the system with the largest enrollments and the greatest risks.

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Subd. 2. **Establishment; committee membership.** The Minnesota Eligibility System Executive Steering Committee is established to govern and administer the Minnesota eligibility system. The steering committee shall be composed of one member appointed by the commissioner of human services, one member appointed by the board, one member appointed jointly by the Association of Minnesota Counties and the Minnesota Inter-County Association, and one nonvoting member appointed by the commissioner of MN.IT services who shall serve as the committee chairperson. Steering committee costs must be paid from the budgets of the Department of Human Services, the Office of MN.IT Services, and MNsure.

Subd. 3. **Duties.** (a) The Minnesota Eligibility System Executive Steering Committee shall establish an overall governance structure for the Minnesota eligibility system and shall be responsible for the overall governance of the system, including setting system goals and priorities, allocating the system's resources, making major system decisions, and tracking total funding and expenditures for the system from all sources. The steering committee shall also report to the Legislative Oversight Committee on a quarterly basis on Minnesota eligibility system funding and expenditures, including amounts received in the most recent quarter by funding source and expenditures made in the most recent quarter by funding source.

(b) The steering committee shall adopt bylaws, policies, and interagency agreements necessary to administer the Minnesota eligibility system.

(c) In making decisions, the steering committee shall give particular attention to the parts of the system with the largest enrollments and the greatest risks.

Subd. 4. **Meetings.** (a) All meetings of the steering committee must:

(1) be held in the State Office Building; and

(2) whenever possible, be available on the legislature's Web site for live streaming and downloading over the Internet.

(b) The steering committee must:

(1) as part of every steering committee meeting, provide the opportunity for oral and written public testimony and comments on steering committee governance of the Minnesota eligibility system; and

(2) provide documents under discussion or review by the steering committee to be electronically posted on the legislature's Web site. Documents must be provided and posted prior to the meeting at which the documents are scheduled for review or discussion.

(c) All votes of the steering committee must be recorded, with each member's vote identified.

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Subd. 5. **Administrative structure.** MN.IT services shall be responsible for the design, build, maintenance, operation, and upgrade of the information technology for the shared eligibility system. MN.IT services shall carry out its responsibilities under the governance of the executive steering committee and this section.

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

Sec. 24. Minnesota Statutes 2014, section 62V.05, subdivision 2, is amended to read:

Subd. 2. **Operations funding.** (a) Prior to January 1, 2015, MNsure shall retain or collect up to 1.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the cash reserves of MNsure, but the amount collected shall not exceed a dollar amount equal to 25 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(b) Beginning January 1, 2015, through December 31, 2015, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected shall not exceed a dollar amount equal to 50 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(c) Beginning January 1, 2016, through December 31, 2017, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected may never exceed a dollar amount greater than 100 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(d) Beginning January 1, 2018, MNsure shall retain or collect up to 1.5 percent of total premiums for individual health plans and dental plans sold to Minnesota residents through MNsure and outside of MNsure to fund the operations of MNsure. The amount collected shall not exceed a dollar amount greater than 100 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

~~(d)~~ (e) For fiscal years 2014 and 2015, the commissioner of management and budget is authorized to provide cash flow assistance of up to $20,000,000 from the special revenue fund or the statutory general fund under section 16A.671, subdivision 3, paragraph (a), to MNsure. Any funds provided under this paragraph shall be repaid, with interest, by June 30, 2015.

~~(e)~~ (f) Funding for the operations of MNsure shall cover any compensation provided to navigators participating in the navigator program.

Subd. 5. **Administrative structure.** The Office of MN.IT Services shall be responsible for the design, build, maintenance, operation, and upgrade of the information technology for the Minnesota eligibility system. The office shall carry out its responsibilities under the governance of the steering committee, this section, and chapter 16E.

Sec. 6. Minnesota Statutes 2014, section 62V.05, subdivision 2, is amended to read:

Subd. 2. **Operations funding.** (a) ~~Prior to January 1, 2015, MNsure shall retain or collect up to 1.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the cash reserves of MNsure, but the amount collected shall not exceed a dollar amount equal to 25 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.~~

~~(b) Beginning January 1, 2015, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected shall not exceed a dollar amount equal to 50 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.~~

~~(e)~~ Beginning January 1, 2016, through December 31, 2016, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure~~, but the amount collected may never exceed a dollar amount greater than 100 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012~~.

(b) Beginning January 1, 2017, through December 31, 2017, MNsure shall retain or collect up to 1.75 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operation of MNsure.

~~(d) For fiscal years 2014 and 2015, the commissioner of management and budget is authorized to provide cash flow assistance of up to $20,000,000 from the special revenue fund or the statutory general fund under section 16A.671, subdivision 3, paragraph (a), to MNsure. Any funds provided under this paragraph shall be repaid, with interest, by June 30, 2015.~~

(e) Funding for the operations of MNsure shall cover any compensation provided to navigators participating in the navigator program.

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(c) If an independent third party makes the certification specified in this paragraph, MNsure shall retain or collect up to 1.75 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure. This paragraph applies to a calendar year beginning on or after January 1, 2018, if in the previous calendar year the independent third party certified that MNsure met all of the following operational and technological benchmarks for the previous calendar year:

(1) on a daily basis, MNsure successfully transferred to health carriers data in the EDI 834 format that were complete and accurate according to industry standards and that allowed the health carrier to enroll the consumer in the qualified health plan chosen by the consumer;

(2) MNsure automatically processed enrollment renewals in qualified health plans and in public health care programs;

(3) MNsure automatically processed invoices for and payments of MinnesotaCare premiums;

(4) MNsure provided self-service functionality for account changes and changes necessitated by qualifying life events, including adding or removing household members, making changes to address or income, canceling coverage, and accessing online proof of coverage forms required by federal law;

(5) MNsure transmitted 1095-A forms to enrollees by January 31 each year, or earlier if required by federal law; and

(6) MNsure call center response and resolution times met or exceeded industry standards.

(d) Beginning January 1, 2018, for any calendar year for which the independent third party did not make the certification specified in paragraph (c) for the previous calendar year, MNsure shall retain or collect up to 1.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operation of MNsure.

(f) The amount collected by MNsure in a calendar year under this subdivision shall not exceed a dollar amount greater than 60 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

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

Sec. 8. Minnesota Statutes 2014, section 62V.05, is amended by adding a subdivision to read:

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Subd. 12. **Legislative enactment required.** (a) The MNsure board shall not enter into or renew any interagency agreement or service level agreement with a value of more than $100,000 a year, or related agreements with a cumulative value of more than $100,000 a year, with a state department, state agency, or the Office of MN.IT Services, unless the specific agreement is authorized by enactment of a new law. If an agreement, including an agreement in effect as of the effective date of this subdivision, does not have an expiration date, the agreement shall expire two years from the effective date of this subdivision or the effective date of the agreement, whichever is later, unless the specific agreement is authorized by enactment of a new law.

(b) Notwithstanding section 16A.285, the board shall not transfer appropriations and funds in amounts over $100,000 across agency accounts or programs unless the specific transfer is authorized by enactment of a new law.

(c) For purposes of this subdivision, "state department" has the meaning provided in section 15.01, and "state agency" has the meaning provided in section 15.012.

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

Sec. 9. Minnesota Statutes 2014, section 62V.05, is amended by adding a subdivision to read:

Subd. 13. **Limitation on appropriations and transfers.** Notwithstanding any other law to the contrary, effective July 1, 2016, no money in or from the general fund, health care access fund, or any other state fund or account, may be: (1) appropriated or made available to MNsure; or (2) transferred or otherwise provided to MNsure by any other state agency or entity of state government, unless the appropriation, transfer, or transaction is specifically authorized through the enactment of a new law.

Section 1. **[62V.055] ADDITIONAL NOTICE TO APPLICANTS.**

The board, in consultation with the commissioner of human services, shall include in the combined application for medical assistance, MinnesotaCare, and qualified health plan coverage available through the MNsure portal, information and notice on the following:

(1) that when an applicant submits the combined application, eligibility for subsidized coverage will be determined in the following order:

(i) medical assistance;

(ii) MinnesotaCare;

(iii) advanced premium tax credits and cost-sharing subsidies; and

(iv) qualified health plan coverage without a subsidy;

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(2) persons eligible for medical assistance are not eligible for MinnesotaCare, and persons eligible for medical assistance or MinnesotaCare are not eligible for advanced premium tax credits and cost-sharing subsidies; and

(3) if a person enrolls in medical assistance, the state may claim repayment for the cost of medical care or premiums paid for that care from the person's estate.

Sec. 11. Minnesota Statutes 2014, section 62V.11, is amended by adding a subdivision to read:

Subd. 5. **Review of Minnesota eligibility system funding and expenditures.** The committee shall review quarterly reports submitted by the Minnesota Eligibility System Executive Steering Committee under section 62V.055, subdivision 3, regarding Minnesota eligibility system funding and expenditures.

Sec. 12. Minnesota Statutes 2014, section 144.05, is amended by adding a subdivision to read:

Subd. 6. **Legislative enactment required.** (a) The commissioner of health shall not enter into or renew any interagency agreement or service level agreement with a value of more than $100,000 a year, or related agreements with a cumulative value of more than $100,000 a year, with a state department, state agency, or the Office of MN.IT Services, unless the specific agreement is authorized by enactment of a new law. If an agreement, including an agreement in effect as of the effective date of this subdivision, does not have an expiration date, the agreement shall expire two years from the effective date of this subdivision or the effective date of the agreement, whichever is later, unless the specific agreement is authorized by enactment of a new law.

(b) Notwithstanding section 16A.285, the commissioner shall not transfer appropriations and funds in amounts over $100,000 across agency accounts or programs unless the specific transfer is authorized by enactment of a new law.

(c) For purposes of this subdivision, "state department" has the meaning provided in section 15.01, and "state agency" has the meaning provided in section 15.012.

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

Sec. 13. Minnesota Statutes 2014, section 256.01, is amended by adding a subdivision to read:

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476.5 Sec. 25. Minnesota Statutes 2014, section 256.01, is amended by adding a subdivision
476.6 to read:

476.7 Subd. 41. **Plan and timetable for processing qualifying life events and changes**
476.8 **in circumstances.** The commissioner and the board of MNsure shall jointly develop
476.9 a plan and timetable for implementation to ensure qualifying life events and changes
476.10 in circumstances, reported by persons enrolled through the MNsure system in a public
476.11 health care program or a qualified health plan, are processed within 30 days of receiving a
476.12 report of a qualifying life event or change in circumstances. The plan and timetable for
476.13 implementation must be developed no later than January 15, 2017.

41.9 Subd. 41. **Legislative enactment required.** (a) The commissioner of human
41.10 services shall not enter into or renew any interagency agreement or service level agreement
41.11 with a value of more than $100,000 a year, or related agreements with a cumulative value
41.12 of more than $100,000 a year, with a state department, state agency, or the Office of
41.13 MN.IT Services, unless the specific agreement is authorized by enactment of a new law. If
41.14 an agreement, including an agreement in effect as of the effective date of this subdivision,
41.15 does not have an expiration date, the agreement shall expire two years from the effective
41.16 date of this subdivision or the effective date of the agreement, whichever is later, unless
41.17 the specific agreement is authorized by enactment of a new law.

41.18 (b) Notwithstanding section 16A.285, the commissioner shall not transfer
41.19 appropriations and funds in amounts over $100,000 across agency accounts or programs
41.20 unless the specific transfer is authorized by enactment of a new law.

41.21 (c) For purposes of this subdivision, "state department" has the meaning provided in
41.22 section 15.01, and "state agency" has the meaning provided in section 15.012.

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

37.14 Sec. 7. Minnesota Statutes 2014, section 62V.05, is amended by adding a subdivision
37.15 to read:

37.16 Subd. 4a. **Processing qualifying life events and changes in circumstances.**
37.17 (a) The MNsure board and the commissioner of human services shall jointly develop
37.18 procedures to require qualifying life events and changes in circumstances, reported by
37.19 persons enrolled through the Minnesota eligibility technology system in a public health
37.20 care program or a qualified health plan, to be processed within 30 days of receiving a report
37.21 of a qualifying life event or change in circumstances. The procedures must be developed
37.22 and implemented no later than September 1, 2016. The commissioner shall communicate
37.23 these procedures to county staff in a timely manner and shall provide guidance and
37.24 training as necessary to assist county staff in complying with this subdivision.

37.25 (b) For purposes of this subdivision, a qualifying life event or change in
37.26 circumstances that must be processed within 30 days includes the following:

37.27 (1) a change of address;

37.28 (2) a change in enrollment in a federally recognized tribe;

37.29 (3) a change of a dependent through birth, adoption, foster care, or a child support
37.30 order;

37.31 (4) a change in circumstances resulting in eligibility changes for advanced premium
37.32 tax credits or cost-sharing reductions;

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(5) a change in employer-sponsored insurance resulting in eligibility changes for advanced premium tax credits or cost-sharing reductions;

(6) loss of a dependent due to death or divorce;

(7) an achievement of citizenship, status as a United States national, or lawfully present status;

(8) loss of health care coverage;

(9) marriage;

(10) being a victim of domestic abuse or spousal abandonment;

(11) a MNsure mistake related to enrollment, disenrollment, or failure to enroll in a qualified health plan;

(12) a violation of a material provision of a qualified health plan contract; and

(13) other life events or changes in circumstances specified by the commissioner or the MNsure board.

Sec. 26. Minnesota Statutes 2014, section 256B.04, subdivision 14, is amended to read:

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

(1) eyeglasses;

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

(3) hearing aids and supplies; and

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

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

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

(ix) allergen-reducing products as described in section 256B.0625, subdivision 65, paragraph (b), clause (3);

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

(6) drugs.

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

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

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Sec. 10. Minnesota Statutes 2014, section 256B.042, is amended by adding a subdivision to read:

Subd. 1a. **Additional notice to applicants.** An application for medical assistance must include a statement, prominently displayed, that if any person on the application enrolls in medical assistance, the state may claim repayment for the cost of medical care or premiums paid for care from that person's estate.

Section 1. **[256B.0562] IMPROVED OVERSIGHT OF MNSURE ELIGIBILITY DETERMINATIONS.**

Subdivision 1. **Implementation of OLA findings.** (a) The commissioner shall ensure that medical assistance and MinnesotaCare eligibility determinations through the MNsure information technology system and through agency eligibility determination systems fully implement the recommendations made by the Office of the Legislative Auditor (OLA) in Report 14-22 – Oversight of MNsure Eligibility Determinations for Public Health Care Programs and Report 16-02 Oversight of MNsure Eligibility Determinations for Public Health Care Programs – Internal Controls and Compliance Audit.

(b) The commissioner may contract with a vendor to provide technical assistance to the commissioner in fully implementing the OLA report findings.

(c) The commissioner shall coordinate implementation of this section with the periodic data matching required under section 256B.0561.

(d) The commissioner shall implement this section using existing resources.

Subd. 2. **Duties of the commissioner.** (a) In fully implementing the OLA report recommendations, the commissioner shall:

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(1) adequately verify that persons enrolled in public health care programs through MNsure are eligible for those programs;

(2) provide adequate controls to ensure the accurate and complete transfer of recipient data from MNsure to the Department of Human Services' medical payment system, and to detect whether Office of MN.IT Services staff inappropriately access recipients' personal information;

(3) provide county human service eligibility workers with sufficient training on MNsure;

(4) reverify that medical assistance and MinnesotaCare enrollees who enroll through MNsure remain eligible for the program within the required time frames established in federal and state laws;

(5) establish an effective process to resolve discrepancies with Social Security numbers, citizenship or immigration status, or household income that MNsure identifies as needing further verification;

(6) eliminate payment of medical assistance and MinnesotaCare benefits for recipients whose income exceeds federal and state program limits;

(7) verify household size and member relationships when determining eligibility;

(8) ensure that applicants and recipients are enrolled in the correct public health care program;

(9) eliminate payment of benefits for MinnesotaCare recipients who are also enrolled in Medicare;

(10) verify that newborns turning age one remain eligible for medical assistance;

(11) correct MinnesotaCare billing errors, ensure that enrollees pay their premiums, and terminate coverage for failure to pay premiums; and

(12) take all other steps necessary to fully implement the recommendations.

(b) The commissioner shall implement the OLA recommendations for medical assistance and MinnesotaCare applications and renewals submitted on or after July 1, 2016. The commissioner shall present quarterly reports to the OLA and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, beginning October 1, 2016, and each quarter thereafter. The quarterly report submitted October 1, 2016, must include a timetable for fully implementing the OLA recommendations. Each quarterly report must include information on:

(1) progress in implementing the OLA recommendations;

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(2) the number of medical assistance and MinnesotaCare applicants and enrollees whose eligibility status was affected by implementation of the OLA recommendations, reported quarterly, beginning with the July 1, 2016 through September 30, 2016 calendar quarter; and

(3) savings to the state from implementing the OLA recommendations.

Subd. 3. **Office of Legislative Auditor.** The legislative auditor shall review each quarterly report submitted by the commissioner of human services under subdivision 2 for accuracy and shall review compliance by the Department of Human Services with the OLA report recommendations. The legislative auditor shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on whether or not these requirements are met.

Subd. 4. **Special revenue account; use of savings.** (a) A medical assistance audit special revenue account is established in the general fund. The commissioner shall deposit into this account: (1) all savings achieved from implementing this section for applications and renewals submitted on or after July 1, 2016; (2) all savings achieved from implementation of periodic data matching under section 256B.0561 that are above the forecasted savings for that initiative; and (3) all state savings resulting from implementation of the vendor contract under section 256B.0563, minus any payments to the vendor made under the terms of the revenue sharing agreement.

(b) Once the medical assistance audit special revenue account fund balance has reached a sufficient level, the commissioner shall provide a onetime, five percent increase in medical assistance payment rates for intermediate care facilities for persons with developmental disabilities and the long-term care and community-based providers listed in Laws 2014, chapter 312, article 27, section 75, paragraph (b). The increase shall be limited to a 12-month period.

(c) Any further expenditures from the medical assistance audit special revenue account are subject to legislative authorization.

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

Sec. 2. **[256B.0563] ELIGIBILITY VERIFICATION.**

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

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

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

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

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

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

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

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

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

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

Sec. 27. Minnesota Statutes 2014, section 256B.057, is amended by adding a subdivision to read:

Subd. 13. **Presumptive eligibility determinations made by federally qualified health centers.** The commissioner shall establish a process to qualify federally qualified health centers, as defined in section 145.9269, subdivision 1, that are participating providers under the medical assistance program to determine presumptive eligibility for medical assistance for an applicant who is a pregnant woman or child under the age of two, and has a basis of eligibility using the modified adjusted gross income methodology as defined in section 256B.056, subdivision 1a, paragraph (b), clause (1).

EFFECTIVE DATE. This section is effective January 1, 2017.

Sec. 28. Minnesota Statutes 2014, section 256B.059, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section and sections 256B.058 and 256B.0595, the terms defined in this subdivision have the meanings given them.

(b) "Community spouse" means the spouse of an institutionalized spouse.

~~(c) "Spousal share" means one-half of the total value of all assets, to the extent that either the institutionalized spouse or the community spouse had an ownership interest at the time of the first continuous period of institutionalization.~~

~~(d)~~ (c) "Assets otherwise available to the community spouse" means assets individually or jointly owned by the community spouse, other than assets excluded by subdivision 5, paragraph (c).

~~(e)~~ (d) "Community spouse asset allowance" is the value of assets that can be transferred under subdivision 3.

~~(f)~~ (e) "Institutionalized spouse" means a person who is:

(1) in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, or receiving home and community-based services under section 256B.0915, and is expected to remain in the facility or institution or receive the home and community-based services for at least 30 consecutive days; and

(2) married to a person who is not in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, and is not receiving home and community-based services under section 256B.0915, 256B.092, or 256B.49.

~~(g)~~ (f) "For the sole benefit of" means no other individual or entity can benefit in any way from the assets or income at the time of a transfer or at any time in the future.

~~(h)~~ (g) "Continuous period of institutionalization" means a 30-consecutive-day period of time in which a person is expected to stay in a medical or long-term care facility, or receive home and community-based services that would qualify for coverage under the elderly waiver (EW) or alternative care (AC) programs. For a stay in a facility, the 30-consecutive-day period begins on the date of entry into a medical or long-term care facility. For receipt of home and community-based services, the 30-consecutive-day period begins on the date that the following conditions are met:

(1) the person is receiving services that meet the nursing facility level of care determined by a long-term care consultation;

(2) the person has received the long-term care consultation within the past 60 days;

(3) the services are paid by the EW program under section 256B.0915 or the AC program under section 256B.0913 or would qualify for payment under the EW or AC programs if the person were otherwise eligible for either program, and but for the receipt of such services the person would have resided in a nursing facility; and

(4) the services are provided by a licensed provider qualified to provide home and community-based services.

EFFECTIVE DATE. This section is effective June 1, 2016.

Sec. 29. Minnesota Statutes 2014, section 256B.059, subdivision 2, is amended to read:

Subd. 2. **Assessment of ~~spousal share~~ marital assets.** ~~At the beginning of the first continuous period of institutionalization of a person beginning on or after October 1, 1989, at the request of either the institutionalized spouse or the community spouse, or~~ Upon application for medical assistance benefits for an institutionalized spouse, the total value of assets in which either the institutionalized spouse or the community spouse ~~had~~ have an interest ~~at the time of the first period of institutionalization of 30 days or more~~ shall be assessed and ~~documented and the spousal share shall be assessed and documented~~ the community spouse asset allowance calculated as required in subdivision 3.

EFFECTIVE DATE. This section is effective June 1, 2016.

Sec. 30. Minnesota Statutes 2014, section 256B.059, subdivision 3, is amended to read:

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Subd. 3. **Community spouse asset allowance.** An institutionalized spouse may transfer assets to the community spouse for the sole benefit of the community spouse. Except for increased amounts allowable under subdivision 4, the maximum amount of assets allowed to be transferred is the amount which, when added to the assets otherwise available to the community spouse, is ~~as follows~~ the greater of:

~~(1) prior to July 1, 1994, the greater of:~~

~~(i) $14,148;~~

~~(ii) the lesser of the spousal share or $70,740; or~~

~~(iii) the amount required by court order to be paid to the community spouse; and~~

~~(2) for persons whose date of initial determination of eligibility for medical assistance following their first continuous period of institutionalization occurs on or after July 1, 1994, the greater of:~~

~~(i) $20,000;~~

~~(ii) the lesser of the spousal share or $70,740; or~~

~~(iii) the amount required by court order to be paid to the community spouse.~~

(1) $119,220 subject to an annual adjustment on January 1, 2017, and every January 1 thereafter, equal to the percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) between the two previous Septembers; or

(2) the amount required by court order to be paid to the community spouse.

If the assets available to the community spouse are already at the limit permissible under this section, or the higher limit attributable to increases under subdivision 4, no assets may be transferred from the institutionalized spouse to the community spouse. The transfer must be made as soon as practicable after the date the institutionalized spouse is determined eligible for medical assistance, or within the amount of time needed for any court order required for the transfer. ~~On January 1, 1994, and every January 1 thereafter, the limits in this subdivision shall be adjusted by the same percentage change in the Consumer Price Index for All Urban Consumers (all items; United States city average) between the two previous Septembers. These adjustments shall also be applied to the limits in subdivision 5.~~

EFFECTIVE DATE. This section is effective June 1, 2016.

Sec. 31. Minnesota Statutes 2015 Supplement, section 256B.059, subdivision 5, is amended to read:

Sec. 11. Minnesota Statutes 2015 Supplement, section 256B.059, subdivision 5, is amended to read:

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Subd. 5. **Asset availability.** (a) At the time of initial determination of eligibility for medical assistance benefits ~~following the first continuous period of institutionalization on or after October 1, 1989~~ for an institutionalized spouse, assets considered available to the institutionalized spouse shall be the total value of all assets in which either spouse has an ownership interest, reduced by the ~~following~~ amount ~~for the community spouse:~~ available to the community spouse under subdivision 3.

~~(1) prior to July 1, 1994, the greater of:~~

~~(i) $14,148;~~

~~(ii) the lesser of the spousal share or $70,740; or~~

~~(iii) the amount required by court order to be paid to the community spouse;~~

~~(2) for persons whose date of initial determination of eligibility for medical assistance following their first continuous period of institutionalization occurs on or after July 1, 1994, the greater of:~~

~~(i) $20,000;~~

~~(ii) the lesser of the spousal share or $70,740; or~~

~~(iii) the amount required by court order to be paid to the community spouse.~~

The value of assets transferred for the sole benefit of the community spouse under section 256B.0595, subdivision 4, in combination with other assets available to the community spouse under this section, cannot exceed the limit for the community spouse asset allowance determined under subdivision 3 or 4. Assets that exceed this allowance shall be considered available to the institutionalized spouse. If the community spouse asset allowance has been increased under subdivision 4, then the assets considered available to the institutionalized spouse under this subdivision shall be further reduced by the value of additional amounts allowed under subdivision 4.

(b) An institutionalized spouse may be found eligible for medical assistance even though assets in excess of the allowable amount are found to be available under paragraph (a) if the assets are owned jointly or individually by the community spouse, and the institutionalized spouse cannot use those assets to pay for the cost of care without the consent of the community spouse, and if: (i) the institutionalized spouse assigns to the commissioner the right to support from the community spouse under section 256B.14, subdivision 3; (ii) the institutionalized spouse lacks the ability to execute an assignment due to a physical or mental impairment; or (iii) the denial of eligibility would cause an imminent threat to the institutionalized spouse's health and well-being.

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Subd. 5. **Asset availability.** (a) At the time of initial determination of eligibility for medical assistance benefits following the first continuous period of institutionalization on or after October 1, 1989, assets considered available to the institutionalized spouse shall be the total value of all assets in which either spouse has an ownership interest, reduced by the following amount for the community spouse:

(1) prior to July 1, 1994, the greater of:

(i) $14,148;

(ii) the lesser of the spousal share or $70,740; or

(iii) the amount required by court order to be paid to the community spouse;

(2) for persons whose date of initial determination of eligibility for medical assistance following their first continuous period of institutionalization occurs on or after July 1, 1994, the greater of:

(i) $20,000;

(ii) the lesser of the spousal share or $70,740; or

(iii) the amount required by court order to be paid to the community spouse.

The value of assets transferred for the sole benefit of the community spouse under section 256B.0595, subdivision 4, in combination with other assets available to the community spouse under this section, cannot exceed the limit for the community spouse asset allowance determined under subdivision 3 or 4. Assets that exceed this allowance shall be considered available to the institutionalized spouse. If the community spouse asset allowance has been increased under subdivision 4, then the assets considered available to the institutionalized spouse under this subdivision shall be further reduced by the value of additional amounts allowed under subdivision 4.

(b) An institutionalized spouse may be found eligible for medical assistance even though assets in excess of the allowable amount are found to be available under paragraph (a) if the assets are owned jointly or individually by the community spouse, and the institutionalized spouse cannot use those assets to pay for the cost of care without the consent of the community spouse, and if:

(i) the institutionalized spouse assigns to the commissioner the right to support from the community spouse under section 256B.14, subdivision 3;

(ii) the institutionalized spouse lacks the ability to execute an assignment due to a physical or mental impairment; ~~or~~

(iii) the denial of eligibility would cause an imminent threat to the institutionalized spouse's health and well-being~~.~~; or

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(iv) the assets in excess of the amount under paragraph (a) are assets owned by the community spouse, and the denial of eligibility would cause an undue hardship to the family due to the loss of retirement funds for the community spouse or funds protected for the postsecondary education of a child under age 25. For purposes of this clause, only retirement assets held by the community spouse in a tax-deferred retirement account, including a defined benefit plan, defined contribution plan, an employer-sponsored individual retirement arrangement, or individually purchased individual retirement arrangement are protected, and are only protected until the community spouse is eligible to withdraw retirement funds from any or all accounts without penalty. For purposes of this clause, only funds in a plan designated under section 529 of the Internal Revenue Code on behalf of a child of either or both spouses who is under the age of 25 are protected. There shall not be an assignment of spousal support to the commissioner or a cause of action against the individual's spouse under section 256B.14, subdivision 3, for the funds in the protected retirement and college savings accounts.

(c) After the month in which the institutionalized spouse is determined eligible for medical assistance, and during the continuous period of ~~institutionalization~~ enrollment, no assets of the community spouse are considered available to the institutionalized spouse, unless the institutionalized spouse has been found eligible under paragraph (b).

(c) After the month in which the institutionalized spouse is determined eligible for medical assistance, during the continuous period of institutionalization, no assets of the community spouse are considered available to the institutionalized spouse, unless the institutionalized spouse has been found eligible under paragraph (b).

(d) Assets determined to be available to the institutionalized spouse under this section must be used for the health care or personal needs of the institutionalized spouse.

(d) Assets determined to be available to the institutionalized spouse under this section must be used for the health care or personal needs of the institutionalized spouse.

(e) For purposes of this section, assets do not include assets excluded under the Supplemental Security Income program.

(e) For purposes of this section, assets do not include assets excluded under the Supplemental Security Income program.

EFFECTIVE DATE. This section is effective June 1, 2016.

EFFECTIVE DATE. This section is effective June 1, 2016.

Sec. 32. Minnesota Statutes 2014, section 256B.059, is amended by adding a subdivision to read:

Subd. 6. **Temporary application.** (a) During the period in which rules against spousal impoverishment are temporarily applied according to section 2404 of the Patient Protection Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, this section applies to an institutionalized spouse:

(1) applying for home and community-based waivers under sections 256B.092, 256B.093, and 256B.49 on or after June 1, 2016;

(2) enrolled in home and community-based waivers under sections 256B.092, 256B.093, and 256B.49 before June 1, 2016; or

(3) applying for services under section 256B.85 upon the effective date of that section.

(b) During the applicable period of paragraph (a), the definition of "institutionalized spouse" in subdivision 1, paragraph (f), also includes an institutionalized spouse referenced in paragraph (a).

EFFECTIVE DATE. (a) Minnesota Statutes, section 256B.059, subdivision 6, paragraphs (a), clauses (1) and (3), and (b) are effective June 1, 2016. Minnesota Statutes, section 256B.059, subdivision 6, paragraph (a), clause (2), is effective March 1, 2017.

(b) Minnesota Statutes, section 256B.059, subdivision 6, paragraph (a), clauses (1) and (2), expire upon notification to the commissioner of human services that the Center for Medicare and Medicaid Services approved the continuation of the deeming rules in effect on May 31, 2016, for the treatment of the assets of a community spouse. The commissioner of human services shall notify the revisor of statutes when notice is received.

Sec. 33. Minnesota Statutes 2014, 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;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) services for routine prenatal care;

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

(v) elective surgery;

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

(vii) preventative health care and family planning services;

(viii) rehabilitation services;

(ix) physical, occupational, or speech therapy;

(x) transportation services;

(xi) case management;

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

(xiii) dental services;

(xiv) hospice care;

(xv) audiology services and hearing aids;

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(xvi) podiatry services;

(xvii) chiropractic services;

(xviii) immunizations;

(xix) vision services and eyeglasses;

(xx) waiver services;

(xxi) individualized education programs; or

(xxii) chemical dependency treatment.

(i) Pregnant noncitizens who are ineligible for federally funded medical assistance because of immigration status, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and 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) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance. The nonprofit center referenced under this paragraph may establish itself as a provider of mental health targeted case management services through a county contract under section 256.0112, subdivision 6. If the nonprofit center is unable to secure a contract with a lead county in its service area, then, notwithstanding the requirements of section 256B.0625, subdivision 20, the commissioner may negotiate a contract with the nonprofit center for provision of mental health targeted case management services. When serving clients who are not the financial responsibility of their contracted lead county, the nonprofit center must gain the concurrence of the county of financial responsibility prior to providing mental health targeted case management services for those clients.

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

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

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

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

(l) Effective July 1, 2013, recipients of emergency medical assistance under this subdivision are eligible for coverage of the elderly waiver services provided under section 256B.0915, and coverage of rehabilitative services provided in a nursing facility. The age limit for elderly waiver services does not apply. In order to qualify for coverage, a recipient of emergency medical assistance is subject to the assessment and reassessment requirements of section 256B.0911. Initial and continued enrollment under this paragraph is subject to the limits of available funding.

Sec. 34. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 9c. **Oral health assessments.** Medical assistance covers oral health assessments that meet the requirements of this subdivision. An oral health assessment must use the risk factors established by the commissioner of human services and be conducted by a licensed dental provider in collaborative practice under section 150A.10, subdivision 1a; 150A.105; or 150A.106, to identify possible signs of oral or systemic disease, malformation, or injury and the need for referral for diagnosis and treatment. Oral health assessments are limited to once per patient per year and must be conducted in a community setting. The provider performing the assessment must document that a formal arrangement with a licensed dentist for patient referral and follow-up is in place and is being utilized. The patient referral and follow-up arrangement must allow patients receiving an assessment under this subdivision to receive follow-up services in a timely manner and establish an ongoing relationship with a dental provider that is available to serve as the patient's dental home. If the commissioner determines from an analysis of claims or other information that the referral and follow-up arrangement is not reasonably effective in ensuring that patients receive follow-up services, the commissioner may disqualify the treating provider or the pay-to provider from receiving payment for assessments under this subdivision.

Sec. 35. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 17a, is amended to read:

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

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Sec. 3. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 17a, is amended to read:

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

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(b) Effective for services provided on or after July 1, 2016, medical assistance payment rates for ambulance services identified in this paragraph are increased by five percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2017, shall be increased to reflect this rate increase, and shall require the plans to pass on the full amount of the increase in the form of higher reimbursement rates to the ambulance service providers identified in this paragraph. The increased rate described in this paragraph applies to ambulance service providers whose base of operations as defined in section 144E.10 is located:

(1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

(2) within a municipality with a population of less than 1,000.

Sec. 36. Minnesota Statutes 2014, section 256B.0625, subdivision 30, is amended to read:

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

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

(b) Effective for services provided on or after July 1, 2016, medical assistance payment rates for ambulance services identified in this paragraph are increased by five percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2017, shall be adjusted to reflect this rate increase. The increased rate described in this paragraph applies to:

(1) an ambulance service provider whose base of operations, as defined in section 144E.10, is located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

(2) an ambulance service provider whose base of operations, as defined in section 144E.10, is located within a municipality with a population of less than 1,000.

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(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 37. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

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

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

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

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

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

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

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

(1) can withstand repeated use;

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

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

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

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) Allergen-reducing products provided according to subdivision 65, paragraph (b), clause (3), shall be considered durable medical equipment.

EFFECTIVE DATE. This section is effective upon federal approval, but not before January 1, 2017. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 38. Minnesota Statutes 2014, section 256B.0625, subdivision 34, is amended to read:

Subd. 34. **Indian health services facilities.** (a) Medical assistance payments and MinnesotaCare payments to facilities of the Indian health service and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, for enrollees who are eligible for federal financial participation, shall be at the option of the facility in accordance with the rate published by the United States Assistant Secretary for Health under the authority of United States Code, title 42, sections 248(a) and 249(b). ~~General assistance medical care payments to facilities of the Indian health services and facilities operated by a tribe or tribal organization for the provision of outpatient medical care services billed after June 30, 1990, must be in accordance with the general assistance medical care rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization.~~ MinnesotaCare payments for enrollees who are not eligible for federal financial participation at facilities of the Indian health service and facilities operated by a tribe or tribal organization for the provision of outpatient medical services must be in accordance with the medical assistance rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization.

(b) Effective upon federal approval, the medical assistance payments to a dually certified facility as defined in subdivision 30, paragraph (j), shall be the encounter rate described in paragraph (a) or a rate that is substantially equivalent for services provided to American Indians and Alaskan Native populations. The rate established under this paragraph for dually certified facilities shall not apply to MinnesotaCare payments.

Sec. 39. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 58, is amended to read:

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

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(b) Effective for services provided on or after July 1, 2016, payment for a complete EPSDT screening shall be increased by five percent. Effective January 1, 2017, capitation payments made to managed care plans and county-based purchasing plans shall be increased to reflect this increase and the commissioner shall require the plans to pass on the full amount of the increase in the form of higher payment rates to the providers. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services.

Sec. 40. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 60a. **Community emergency medical technician services.** (a) Medical assistance covers services provided by a community emergency medical technician (CEMT) who is certified under section 144E.275, subdivision 7, when the services are provided in accordance with this subdivision.

(b) A CEMT may provide a posthospital discharge visit when ordered by a treating physician. The posthospital discharge visit includes:

(1) verbal or visual reminders of discharge orders;

(2) recording and reporting of vital signs to the patient's primary care provider;

(3) medication access confirmation;

(4) food access confirmation; and

(5) identification of home hazards.

(c) An individual who has repeat ambulance calls due to falls, has been discharged from a nursing home, or identified by the individual's primary care provider as at risk for nursing home placement, may receive a safety evaluation visit from a CEMT when ordered by a primary care provider in accordance with the individual's care plan. A safety evaluation visit includes:

(1) medication access confirmation;

(2) food access confirmation; and

(3) identification of home hazards.

(d) A CEMT shall be paid at $9.75 per 15-minute increment. A safety evaluation visit may not be billed for the same day as a posthospital discharge visit for the same individual.

EFFECTIVE DATE. This section is effective January 1, 2017, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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Sec. 4. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 60a. **Community emergency medical technician services.** (a) Medical assistance covers services provided by a community emergency medical technician (CEMT) who is certified under section 144E.275, subdivision 7, when the services are provided in accordance with this subdivision.

(b) A CEMT may provide a posthospital discharge visit when ordered by a treating physician. The posthospital discharge visit includes:

(1) verbal or visual reminders of discharge orders;

(2) recording and reporting of vital signs to the patient's primary care provider;

(3) medication access confirmation;

(4) food access confirmation; and

(5) identification of home hazards.

(c) Individuals who have repeat ambulance calls due to falls, have been discharged from a nursing home, or have been identified by their primary care provider as at risk for nursing home placement may receive a safety evaluation visit from a CEMT when ordered by a primary care provider in accordance with the individual's care plan. A safety evaluation visit includes:

(1) medication access confirmation;

(2) food access confirmation; and

(3) identification of home hazards.

(d) A CEMT shall be paid at $9.75 per 15-minute increment. A safety evaluation visit may not be billed for the same day as a posthospital discharge visit for the same recipient.

EFFECTIVE DATE. This section is effective January 1, 2017, or upon federal approval, whichever is later.

Sec. 41. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 65. **Enhanced asthma care services.** (a) Medical assistance covers enhanced asthma care services and related products for children with poorly controlled asthma to be provided in the child's home. To be eligible for services and products under this subdivision, a child must:

(1) be under 21 years of age;

(2) have poorly controlled asthma;

(3) have, at least one time in the past year, received health care for the child's asthma from a hospital emergency department or been hospitalized for the treatment of asthma; and

(4) receive a referral for asthma care services and products covered under this subdivision from a treating health care provider.

(b) Covered asthma care services and products include:

(1) a home assessment for asthma triggers provided by an enrolled healthy homes specialist currently credentialed by the National Environmental Health Association;

(2) targeted asthma education services in the child's home by an enrolled asthma educator certified by the National Asthma Educator Certification Board. Asthma education services provided under this clause include education on self-management, avoiding asthma triggers, identifying worsening asthma symptoms, and medication uses and techniques; and

(3) allergen-reducing products recommended for the child by the healthy homes specialist or the certified asthma educator based on the documented allergies for that child and proven to reduce asthma triggers identified in the child's home assessment, including:

(i) encasements for mattresses, box springs, and pillows;

(ii) a HEPA vacuum cleaner, filters, and bags;

(iii) a dehumidifier and filters;

(iv) single-room air cleaners and filters;

(v) nontoxic pest control systems, including traps and starter packages of food storage containers;

(vi) a damp mopping system;

(vii) if the child does not have access to a bed, a waterproof hospital-grade mattress; and

(viii) furnace filters, for homeowners only.

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(c) A child is limited to one home assessment and one visit by a certified asthma educator to provide education on the use and maintenance of the products listed in paragraph (b), clause (3). A child may receive an additional home assessment if the child moves to a new home: (1) develops a new asthma trigger, including tobacco smoke; or (2) the child's health care provider documents a new allergy for the child, including an allergy to mold, pests, pets, or dust mites.

(d) The commissioner shall determine the frequency that a child may receive a product listed in paragraph (b), clause (3), based on the reasonable expected lifetime of the product.

EFFECTIVE DATE. This section is effective upon federal approval, but not before January 1, 2017. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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Sec. 5. Minnesota Statutes 2014, section 256B.0644, is amended to read:

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

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

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

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

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

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

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

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

Sec. 42. Minnesota Statutes 2014, section 256B.15, subdivision 1, is amended to read:

Subdivision 1. **Policy and applicability.** (a) It is the policy of this state that individuals or couples, either or both of whom participate in the medical assistance program, use their own assets to pay their share of the ~~total~~ cost of their care during or after their enrollment in the program according to applicable federal law and the laws of this state. The following provisions apply:

(1) subdivisions 1c to 1k shall not apply to claims arising under this section which are presented under section 525.313;

(2) the provisions of subdivisions 1c to 1k expanding the interests included in an estate for purposes of recovery under this section give effect to the provisions of United States Code, title 42, section 1396p, governing recoveries, but do not give rise to any express or implied liens in favor of any other parties not named in these provisions;

(3) the continuation of a recipient's life estate or joint tenancy interest in real property after the recipient's death for the purpose of recovering medical assistance under this section modifies common law principles holding that these interests terminate on the death of the holder;

(4) all laws, rules, and regulations governing or involved with a recovery of medical assistance shall be liberally construed to accomplish their intended purposes;

(5) a deceased recipient's life estate and joint tenancy interests continued under this section shall be owned by the remainderpersons or surviving joint tenants as their interests may appear on the date of the recipient's death. They shall not be merged into the remainder interest or the interests of the surviving joint tenants by reason of ownership. They shall be subject to the provisions of this section. Any conveyance, transfer, sale, assignment, or encumbrance by a remainderperson, a surviving joint tenant, or their heirs, successors, and assigns shall be deemed to include all of their interest in the deceased recipient's life estate or joint tenancy interest continued under this section; and

(6) the provisions of subdivisions 1c to 1k continuing a recipient's joint tenancy interests in real property after the recipient's death do not apply to a homestead owned of record, on the date the recipient dies, by the recipient and the recipient's spouse as joint tenants with a right of survivorship. Homestead means the real property occupied by the surviving joint tenant spouse as their sole residence on the date the recipient dies and classified and taxed to the recipient and surviving joint tenant spouse as homestead property for property tax purposes in the calendar year in which the recipient dies. For purposes of this exemption, real property the recipient and their surviving joint tenant spouse purchase solely with the proceeds from the sale of their prior homestead, own of record as joint tenants, and qualify as homestead property under section 273.124 in the calendar year in which the recipient dies and prior to the recipient's death shall be deemed to be real property classified and taxed to the recipient and their surviving joint tenant spouse as homestead property in the calendar year in which the recipient dies. The surviving spouse, or any person with personal knowledge of the facts, may provide an affidavit describing the homestead property affected by this clause and stating facts showing compliance with this clause. The affidavit shall be prima facie evidence of the facts it states.

(b) For purposes of this section, "medical assistance" includes the medical assistance program under this chapter and the general assistance medical care program under chapter 256D and alternative care for nonmedical assistance recipients under section 256B.0913.

(c) For purposes of this section, beginning January 1, 2010, "medical assistance" does not include Medicare cost-sharing benefits in accordance with United States Code, title 42, section 1396p.

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(d) All provisions in this subdivision, and subdivisions 1d, 1f, 1g, 1h, 1i, and 1j, related to the continuation of a recipient's life estate or joint tenancy interests in real property after the recipient's death for the purpose of recovering medical assistance, are effective only for life estates and joint tenancy interests established on or after August 1, 2003. For purposes of this paragraph, medical assistance does not include alternative care.

Sec. 43. Minnesota Statutes 2014, section 256B.15, subdivision 1a, is amended to read:

Subd. 1a. **Estates subject to claims.** (a) If a person receives ~~any~~ medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married couple, either or both of whom received medical assistance, or as otherwise provided for in this section, the ~~total~~ amount paid for medical assistance ~~rendered~~ as limited under subdivision 2 for the person and spouse shall be filed as a claim against the estate of the person or the estate of the surviving spouse in the court having jurisdiction to probate the estate or to issue a decree of descent according to sections 525.31 to 525.313.

(b) For the purposes of this section, the person's estate must consist of:

(1) the person's probate estate;

(2) all of the person's interests or proceeds of those interests in real property the person owned as a life tenant or as a joint tenant with a right of survivorship at the time of the person's death;

(3) all of the person's interests or proceeds of those interests in securities the person owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time of the person's death, to the extent the interests or proceeds of those interests become part of the probate estate under section 524.6-307;

(4) all of the person's interests in joint accounts, multiple-party accounts, and pay-on-death accounts, brokerage accounts, investment accounts, or the proceeds of those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the person's death to the extent the interests become part of the probate estate under section 524.6-207; and

(5) assets conveyed to a survivor, heir, or assign of the person through survivorship, living trust, or other arrangements.

(c) For the purpose of this section and recovery in a surviving spouse's estate for medical assistance paid for a predeceased spouse, the estate must consist of all of the legal title and interests the deceased individual's predeceased spouse had in jointly owned or marital property at the time of the spouse's death, as defined in subdivision 2b, and the proceeds of those interests, that passed to the deceased individual or another individual, a survivor, an heir, or an assign of the predeceased spouse through a joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. A deceased recipient who, at death, owned the property jointly with the surviving spouse shall have an interest in the entire property.

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Sec. 12. Minnesota Statutes 2014, section 256B.15, subdivision 1a, is amended to read:

Subd. 1a. **Estates subject to claims.** (a) If a person receives any medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married couple, either or both of whom received medical assistance, or as otherwise provided for in this section, the total amount paid for medical assistance rendered for the person and spouse shall be filed as a claim against the estate of the person or the estate of the surviving spouse in the court having jurisdiction to probate the estate or to issue a decree of descent according to sections 525.31 to 525.313.

(b) For the purposes of this section, the person's estate must consist of:

(1) the person's probate estate;

(2) all of the person's interests or proceeds of those interests in real property the person owned as a life tenant or as a joint tenant with a right of survivorship at the time of the person's death;

(3) all of the person's interests or proceeds of those interests in securities the person owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time of the person's death, to the extent the interests or proceeds of those interests become part of the probate estate under section 524.6-307;

(4) all of the person's interests in joint accounts, multiple-party accounts, and pay-on-death accounts, brokerage accounts, investment accounts, or the proceeds of those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the person's death to the extent the interests become part of the probate estate under section 524.6-207; and

(5) assets conveyed to a survivor, heir, or assign of the person through survivorship, living trust, or other arrangements.

(c) For the purpose of this section and recovery in a surviving spouse's estate for medical assistance paid for a predeceased spouse, the estate must consist of all of the legal title and interests the deceased individual's predeceased spouse had in jointly owned or marital property at the time of the spouse's death, as defined in subdivision 2b, and the proceeds of those interests, that passed to the deceased individual or another individual, a survivor, an heir, or an assign of the predeceased spouse through a joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. A deceased recipient who, at death, owned the property jointly with the surviving spouse shall have an interest in the entire property.

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(d) For the purpose of recovery in a single person's estate or the estate of a survivor of a married couple, "other arrangement" includes any other means by which title to all or any part of the jointly owned or marital property or interest passed from the predeceased spouse to another including, but not limited to, transfers between spouses which are permitted, prohibited, or penalized for purposes of medical assistance.

(e) A claim shall be filed if medical assistance was rendered for either or both persons under one of the following circumstances:

(1) the person was over 55 years of age, and received services under this chapter prior to January 1, 2014;

(2) the person resided in a medical institution for six months or longer, received services under this chapter, and, at the time of institutionalization or application for medical assistance, whichever is later, the person could not have reasonably been expected to be discharged and returned home, as certified in writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with developmental disabilities, nursing facility, or inpatient hospital; ~~or~~

(3) the person received general assistance medical care services under chapter 256D~~.~~; or

(4) the person was 55 years of age or older and received medical assistance services on or after January 1, 2014, that consisted of nursing facility services, home and community-based services, or related hospital and prescription drug benefits.

(f) The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Notwithstanding any law or rule to the contrary, a state or county agency with a claim under this section must be a creditor under section 524.6-307. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Notice of the claim shall be given to all heirs and devisees of the decedent, and to other persons with an ownership interest in the real property owned by the decedent at the time of the decedent's death, whose identity can be ascertained with reasonable diligence. The notice must include procedures and instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application and determination; and information regarding appeal rights and procedures. Counties are entitled to one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort. Counties are entitled to ten percent of the collections for alternative care directly attributable to county effort.

EFFECTIVE DATE. This section is effective upon federal approval and applies to services rendered on or after January 1, 2014, and to claims not paid prior to July 1, 2016.

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(d) For the purpose of recovery in a single person's estate or the estate of a survivor of a married couple, "other arrangement" includes any other means by which title to all or any part of the jointly owned or marital property or interest passed from the predeceased spouse to another including, but not limited to, transfers between spouses which are permitted, prohibited, or penalized for purposes of medical assistance.

(e) A claim shall be filed if medical assistance was rendered for either or both persons under one of the following circumstances:

(1) the person was over 55 years of age, and received services under this chapter prior to January 1, 2014;

(2) the person resided in a medical institution for six months or longer, received services under this chapter, and, at the time of institutionalization or application for medical assistance, whichever is later, the person could not have reasonably been expected to be discharged and returned home, as certified in writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with developmental disabilities, nursing facility, or inpatient hospital; ~~or~~

(3) the person received general assistance medical care services under chapter 256D~~.~~; or

(4) the person was 55 years of age or older and received medical assistance services on or after January 1, 2014, that consisted of nursing facility services, home and community-based services, or related hospital and prescription drug benefits.

(f) The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Notwithstanding any law or rule to the contrary, a state or county agency with a claim under this section must be a creditor under section 524.6-307. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Notice of the claim shall be given to all heirs and devisees of the decedent, and to other persons with an ownership interest in the real property owned by the decedent at the time of the decedent's death, whose identity can be ascertained with reasonable diligence. The notice must include procedures and instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application and determination; and information regarding appeal rights and procedures. Counties are entitled to one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort. Counties are entitled to ten percent of the collections for alternative care directly attributable to county effort.

EFFECTIVE DATE. This section is effective upon federal approval and applies retroactively to services rendered on or after January 1, 2014.

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14.8 Sec. 13. Minnesota Statutes 2014, section 256B.15, is amended by adding a
14.9 subdivision to read:

14.10 Subd. 1l. **Amending notices or liens arising out of notice.** (a) State agencies must
14.11 amend notices of potential claims and liens arising from the notices, if the notice was filed
14.12 after January 1, 2014, for medical assistance services rendered on or after January 1, 2014,
14.13 to a recipient who at the time services were rendered was 55 years of age or older and who
14.14 was not institutionalized as described in subdivision 1a, paragraph (e).

14.15 (b) The notices identified in paragraph (a) must be amended by removing the
14.16 amount of medical assistance rendered that did not consist of nursing facility services,
14.17 home and community-based services, as defined in subdivision 1a and related hospital
14.18 and prescription drug services.

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

497.9 Sec. 44. Minnesota Statutes 2014, section 256B.15, subdivision 2, is amended to read:

497.10 Subd. 2. **Limitations on claims.** (a) For services rendered prior to January 1, 2014,
497.11 the claim shall include only the total amount of medical assistance rendered after age 55 or
497.12 during a period of institutionalization described in subdivision 1a, paragraph (e), and the
497.13 total amount of general assistance medical care rendered, and shall not include interest.

497.14 (b) For services rendered on or after January 1, 2014, the claim shall include only:

497.15 (1) the amount of medical assistance rendered to recipients 55 years of age or older
497.16 and that consisted of nursing facility services, home and community-based services, and
497.17 related hospital and prescription drug services; and

497.18 (2) the total amount of medical assistance rendered during a period of
497.19 institutionalization described in subdivision 1a, paragraph (e), clause (2).

497.20 The claim shall not include interest. For the purposes of this section, "home and
497.21 community-based services" has the same meaning it has when used in United States
497.22 Code, title 42, section 1396p(b)(1)(B)(i).

14.20 Sec. 14. Minnesota Statutes 2014, section 256B.15, subdivision 2, is amended to read:

14.21 Subd. 2. **Limitations on claims.** (a) For services rendered prior to January 1, 2014,
14.22 the claim shall include only the total amount of medical assistance rendered after age 55 or
14.23 during a period of institutionalization described in subdivision 1a, paragraph (e), and the
14.24 total amount of general assistance medical care rendered, and shall not include interest.

14.25 (b) For services rendered on or after January 1, 2014, the claim shall include only:

14.26 (1) the amount of medical assistance rendered to recipients 55 years of age or older
14.27 and that consisted of nursing facility services, home and community-based services, and
14.28 related hospital and prescription drug services; and

14.29 (2) the total amount of medical assistance rendered during a period of
14.30 institutionalization described in subdivision 1a, paragraph (e).

14.31 The claim shall not include interest. For the purposes of this section, "home and
14.32 community-based services" has the same meaning it has when used in United States Code,
14.33 title 42, section 1396p, subsection (b), paragraph (1), subparagraph (B), clause (i).

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(c) Claims that have been allowed but not paid shall bear interest according to section 524.3-806, paragraph (d). A claim against the estate of a surviving spouse who did not receive medical assistance, for medical assistance rendered for the predeceased spouse, shall be payable from the full value of all of the predeceased spouse's assets and interests which are part of the surviving spouse's estate under subdivisions 1a and 2b. Recovery of medical assistance expenses in the nonrecipient surviving spouse's estate is limited to the value of the assets of the estate that were marital property or jointly owned property at any time during the marriage. The claim is not payable from the value of assets or proceeds of assets in the estate attributable to a predeceased spouse whom the individual married after the death of the predeceased recipient spouse for whom the claim is filed or from assets and the proceeds of assets in the estate which the nonrecipient decedent spouse acquired with assets which were not marital property or jointly owned property after the death of the predeceased recipient spouse. Claims for alternative care shall be net of all premiums paid under section 256B.0913, subdivision 12, on or after July 1, 2003, and shall be limited to services provided on or after July 1, 2003. Claims against marital property shall be limited to claims against recipients who died on or after July 1, 2009.

EFFECTIVE DATE. This section is effective upon federal approval and applies to services rendered on or after January 1, 2014, and to claims not paid prior to July 1, 2016.

Sec. 45. Minnesota Statutes 2014, 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.

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(c) Claims that have been allowed but not paid shall bear interest according to section 524.3-806, paragraph (d). A claim against the estate of a surviving spouse who did not receive medical assistance, for medical assistance rendered for the predeceased spouse, shall be payable from the full value of all of the predeceased spouse's assets and interests which are part of the surviving spouse's estate under subdivisions 1a and 2b. Recovery of medical assistance expenses in the nonrecipient surviving spouse's estate is limited to the value of the assets of the estate that were marital property or jointly owned property at any time during the marriage. The claim is not payable from the value of assets or proceeds of assets in the estate attributable to a predeceased spouse whom the individual married after the death of the predeceased recipient spouse for whom the claim is filed or from assets and the proceeds of assets in the estate which the nonrecipient decedent spouse acquired with assets which were not marital property or jointly owned property after the death of the predeceased recipient spouse. Claims for alternative care shall be net of all premiums paid under section 256B.0913, subdivision 12, on or after July 1, 2003, and shall be limited to services provided on or after July 1, 2003. Claims against marital property shall be limited to claims against recipients who died on or after July 1, 2009.

EFFECTIVE DATE. This section is effective upon federal approval and applies to services rendered on or after January 1, 2014.

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(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) Managed care plans and county-based purchasing plans must comply with chapter 62M and section 62Q.83.

Sec. 46. Minnesota Statutes 2015 Supplement, section 256B.76, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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(h) Effective for services provided on or after July 1, 2016, payment rates for primary care services that were eligible for the rate increase in 2013 and 2014 under section 1902(a)(13)(c) of the Social Security Act shall be increased by five percent when that service is provided by a provider meeting one of the following criteria:

(1) a physician certified in the specialties of family medicine, general internal medicine, pediatric medicine, or obstetric and gynecological medicine; or

(2) a physician assistant, advanced practice registered nurse, or physician other than a psychiatrist, for whom at least 60 percent of the services for which the provider received payment under medical assistance and MinnesotaCare were for primary care evaluation and management services or vaccine administration services under the Vaccines for Children program. The commissioner shall periodically validate the eligibility of providers who attest to meeting the criteria established under this clause.

Effective January 1, 2017, capitation payments made to managed care plans and county-based purchasing plans shall be increased to reflect this increase, and the commissioner shall require the plans to pass on the full amount of the increase in the form of higher payment rates to eligible providers. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services.

Sec. 47. Minnesota Statutes 2015 Supplement, section 256B.76, subdivision 2, is amended to read:

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

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

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

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

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Sec. 6. Minnesota Statutes 2015 Supplement, section 256B.76, subdivision 2, is amended to read:

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

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

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

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

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(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

(j) Effective for services rendered on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

(k) Effective for services rendered on or after July 1, 2015, through December 31, 2016, the commissioner shall increase payment rates for services furnished by dental providers located outside of the seven-county metropolitan area by the maximum percentage possible above the rates in effect on June 30, 2015, while remaining within the limits of funding appropriated for this purpose. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2016, through December 31, 2016, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph. The commissioner shall require managed care and county-based purchasing plans to pass on the full amount of the increase, in the form of higher payment rates to dental providers located outside of the seven-county metropolitan area.

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(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

(j) Effective for services rendered on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

(k) Effective for services rendered on or after July 1, 2015, through December 31, 2016, the commissioner shall increase payment rates for services furnished by dental providers located outside of the seven-county metropolitan area by the maximum percentage possible above the rates in effect on June 30, 2015, while remaining within the limits of funding appropriated for this purpose. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2016, through December 31, 2016, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph. The commissioner shall require managed care and county-based purchasing plans to pass on the full amount of the increase, in the form of higher payment rates to dental providers located outside of the seven-county metropolitan area.

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(l) Effective for services provided on or after January 1, 2017, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph. The commissioner shall require managed care and county-based purchasing plans to pass on the full amount of the increase in the form of higher payment rates to dental providers for the dental services that are identified for the rate increase in this paragraph.

(m) Effective for services provided on or after July 1, 2016, payment rates for preventive dental services shall be increased by five percent. Effective January 1, 2017, capitation payments made to managed care plans and county-based purchasing plans shall be increased to reflect this increase, and the commissioner shall require the plans to pass on the full amount of the increase in the form of higher payment rates for these services. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services.

Sec. 48. Minnesota Statutes 2015 Supplement, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) ~~Effective for dental services rendered on or after January 1, 2002,~~ The commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, ~~2007~~ 2016, the commissioner shall increase reimbursement by ~~35~~ 37.5 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) For dental services rendered on or after July 1, 2016, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (d), clause (4), and is owned and operated by a health maintenance organization licensed under chapter 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.

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(l) Effective for services provided on or after January 1, 2017, the commissioner shall increase payment rates by 9.65 percent above the rates in effect on June 30, 2015, for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

Sec. 7. Minnesota Statutes 2015 Supplement, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) ~~Effective for dental services rendered on or after January 1, 2002,~~ The commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, ~~2007~~ 2016, the commissioner shall increase reimbursement by ~~35~~ 36 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified under paragraph (b). For dental services rendered on or after July 1, 2017, the commissioner shall increase reimbursement by 37 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider, except as specified in paragraph (b). The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) For dental services rendered on or after July 1, 2016, by a dental clinic or dental group that meets the critical access dental provider designation under paragraph (d), clause (4), and is owned and operated by a health maintenance organization licensed under chapter 62D, the commissioner shall increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access provider.

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~~(b)~~ (c) Critical access dental payments made under paragraph (a) or (b) for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

(d) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

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

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) ~~city or county~~ hospital-based dental clinics owned and operated ~~hospital-based dental clinics~~ by a city, county, or former state hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

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~~(b)~~ (c) Critical access dental payments made under paragraph (a) or (b) for dental services provided by a critical access dental provider to an enrollee of a managed care plan or county-based purchasing plan must not reflect any capitated payments or cost-based payments from the managed care plan or county-based purchasing plan. The managed care plan or county-based purchasing plan must base the additional critical access dental payment on the amount that would have been paid for that service had the dental provider been paid according to the managed care plan or county-based purchasing plan's fee schedule that applies to dental providers that are not paid under a capitated payment or cost-based payment.

(d) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

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

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) ~~city or county~~ hospital-based dental clinics owned and operated ~~hospital-based dental clinics~~ by a city, county, or former state hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

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(i) the dentist's office is located within ~~a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E;~~

~~(ii) more~~ the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; ~~and~~ or

~~(iii) the level of service provided by the dentist is critical to maintaining adequate levels of patient access within the service area in which the dentist operates.~~

(ii) the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

Sec. 49. Minnesota Statutes 2014, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) The commissioner shall establish three levels of payment for mental health diagnostic assessment, based on three levels of complexity. The aggregate payment under the tiered rates must not exceed the projected aggregate payments for mental health diagnostic assessment under the previous single rate. The new rate structure is effective January 1, 2011, or upon federal approval, whichever is later.

(d) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

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(i) the dentist's office is located within ~~a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E;~~

~~(ii) more~~ the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; ~~and~~ or

~~(iii) the level of service provided by the dentist is critical to maintaining adequate levels of patient access within the service area in which the dentist operates.~~

(ii) the dentist's office is located outside the seven-county metropolitan area and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.

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(e) Effective for services provided on or after July 1, 2016, payments for outpatient mental health services shall be increased by five percent. Effective January 1, 2017, capitation payments made to managed care plans and county-based purchasing plans shall be increased to reflect this increase, and the commissioner shall require the plans to pass on the full amount of the increase in the form of higher payment rates for these services. This increase is not applicable to federally qualified health centers, rural health centers, Indian health services, other cost-based rates, rates that are negotiated with the county, or rates that are established by the federal government.

Sec. 50. **[256B.7625] REIMBURSEMENT FOR EVIDENCE-BASED PUBLIC HEALTH NURSE HOME VISITS.**

Effective for services provided on or after January 1, 2017, prenatal and postpartum follow-up home visits provided by public health nurses using evidence-based models shall be paid $140 per visit. Evidence-based postpartum follow-up home visits must be administered by home visiting programs that meet the United States Department of Health and Human Services criteria for evidence-based models and identified by the commissioner of health as eligible services under the Maternal, Infant, and Early Childhood Home Visiting program. Home visits shall be targeted toward pregnant women and mothers with children up to three years of age. Effective January 1, 2017, capitation payments made to managed care plans and county-based purchasing plans shall be increased to reflect this increase and the commissioner shall require the plans to pass on the full amount of the increase in the form of higher payment rates to the providers.

Sec. 51. Minnesota Statutes 2015 Supplement, section 256B.766, is amended to read:
256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

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Sec. 8. Minnesota Statutes 2015 Supplement, section 256B.766, is amended to read:
256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

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(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(f) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates as determined under paragraph (i).

(g) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, and laboratory services to a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

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(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(f) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates as determined under paragraph (i).

(g) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, and laboratory services to a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

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(i) Effective July 1, 2015, the ~~medical assistance payment rate for durable medical equipment, prosthetics, orthotics, or supplies shall be restored to the January 1, 2008, medical assistance fee schedule, updated to include subsequent rate increases in the Medicare and medical assistance fee schedules, and including~~ following categories of durable medical equipment shall be individually priced items ~~for the following categories~~: enteral nutrition and supplies, customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service. This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item. The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.

(j) Effective July 1, 2015, medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased as follows:

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare 2008 competitive bid shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare 2008 competitive bid, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, items provided to dually eligible recipients when Medicare is the primary payer for the item, and individually priced items identified in paragraph (i). Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the rate increases in this paragraph.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2015.

Sec. 52. Minnesota Statutes 2014, section 256L.01, subdivision 1a, is amended to read:

Subd. 1a. **Child.** "Child" means an individual under 21 years of age~~, including the unborn child of a pregnant woman, an emancipated minor, and an emancipated minor's spouse~~.

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

Sec. 53. Minnesota Statutes 2015 Supplement, section 256L.01, subdivision 5, is amended to read:

Subd. 5. **Income.** "Income" has the meaning given for modified adjusted gross income, as defined in Code of Federal Regulations, title 26, section 1.36B-1, and means a household's ~~projected annual income for the applicable tax year~~ current income, or if income fluctuates month to month, the income for the 12-month eligibility period.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 54. Minnesota Statutes 2015 Supplement, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Except as otherwise provided in this subdivision, the MinnesotaCare benefit plan shall include the following cost-sharing requirements for all enrollees:

(1) $3 per prescription for adult enrollees;

(2) $25 for eyeglasses for adult enrollees;

(3) $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;

(4) $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

(5) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next-higher five cent increment.

(b) Paragraph (a) does not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 447.51.

(c) Paragraph (a), clause (3), does not apply to mental health services.

(d) 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 (4), effective January 1, 2011.

(e) The commissioner, through the contracting process under section 256L.12, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (5). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

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(f) The commissioner shall increase co-payments for covered services in a manner sufficient to reduce the actuarial value of the benefit to 94 percent for recipients with incomes not exceeding 200 percent of the federal poverty guidelines. The commissioner shall increase co-payments for covered services in a manner sufficient to reduce the actuarial value of the benefit to 87 percent for recipients with incomes greater than 200 percent but not exceeding 250 percent of the federal poverty guidelines. The commissioner shall increase co-payments for covered services in a manner sufficient to reduce the actuarial value of the benefit to 80 percent for recipients with incomes greater than 250 percent but not exceeding 275 percent of the federal poverty guidelines. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. ~~The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.~~

(g) The cost-sharing changes authorized under paragraph (f) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

EFFECTIVE DATE. This section is effective January 1, 2018, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 55. Minnesota Statutes 2014, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** Families with children with family income above 133 percent of the federal poverty guidelines and equal to or less than ~~200~~ 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18 shall apply unless otherwise specified. Children under age 19 with family income at or below ~~200~~ 275 percent of the federal poverty guidelines and who are ineligible for medical assistance by sole reason of the application of federal household composition rules for medical assistance are eligible for MinnesotaCare.

EFFECTIVE DATE. This section is effective January 1, 2018, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 56. Minnesota Statutes 2014, section 256L.04, subdivision 1a, is amended to read:

Subd. 1a. **Social Security number required.** ~~(a)~~ Individuals and families applying for MinnesotaCare coverage must provide a Social Security number if required by Code of Federal Regulations, title 45, section 155.310(a)(3).

~~(b) The commissioner shall not deny eligibility to an otherwise eligible applicant who has applied for a Social Security number and is awaiting issuance of that Social Security number.~~

~~(c) Newborns enrolled under section 256L.05, subdivision 3, are exempt from the requirements of this subdivision.~~

~~(d) Individuals who refuse to provide a Social Security number because of well-established religious objections are exempt from the requirements of this subdivision. The term "well-established religious objections" has the meaning given in Code of Federal Regulations, title 42, section 435.910.~~

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

Sec. 57. Minnesota Statutes 2014, section 256L.04, subdivision 2, is amended to read:

Subd. 2. **Third-party liability, paternity, and other medical support.** ~~(a) To be eligible for MinnesotaCare,~~ Individuals and families ~~must~~ may cooperate with the state agency to identify potentially liable third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited to, complying with the notice requirements in section 256B.056, subdivision 9, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third-party payments.

~~(b) A parent, guardian, relative caretaker, or child enrolled in the MinnesotaCare program must cooperate with the Department of Human Services and the local agency in establishing the paternity of an enrolled child and in obtaining medical care support and payments for the child and any other person for whom the person can legally assign rights, in accordance with applicable laws and rules governing the medical assistance program. A child shall not be ineligible for or disenrolled from the MinnesotaCare program solely because the child's parent, relative caretaker, or guardian fails to cooperate in establishing paternity or obtaining medical support.~~

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

Sec. 58. Minnesota Statutes 2014, section 256L.04, subdivision 7, is amended to read:

Subd. 7. **Single adults and households with no children.** The definition of eligible persons includes all individuals and families with no children who have incomes that are above 133 percent and equal to or less than ~~200~~ 275 percent of the federal poverty guidelines for the applicable family size.

EFFECTIVE DATE. This section is effective January 1, 2018, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 59. Minnesota Statutes 2015 Supplement, section 256L.04, subdivision 7b, is amended to read:

Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income limits under this section annually ~~on January~~ each July 1 as ~~provided~~ described in ~~Code of Federal Regulations, title 26, section 1.36B-1(h)~~ section 256B.056, subdivision 1c.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 60. Minnesota Statutes 2015 Supplement, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Redetermination of eligibility.** (a) An enrollee's eligibility must be redetermined on an annual basis, in accordance with Code of Federal Regulations, title 42, section 435.916(a). ~~The period of eligibility is the entire calendar year following the year in which eligibility is redetermined. Beginning in calendar year 2015, eligibility redeterminations shall occur during the open enrollment period for qualified health plans as specified in Code of Federal Regulations, title 45, section 155.410.~~ The 12-month eligibility period begins the month of application. Beginning July 1, 2017, the commissioner shall adjust the eligibility period for enrollees to implement renewals throughout the year according to guidance from the Centers for Medicare and Medicaid Services.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. Coverage begins as provided in section 256L.06.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 61. Minnesota Statutes 2015 Supplement, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month following the month for which the premium was due. Persons disenrolled for nonpayment may not reenroll prior to the first day of the month following the payment of an amount equal to two months' premiums.

(e) The commissioner shall forgive the past-due premium for persons disenrolled under paragraph (d) prior to issuing a premium invoice for the fourth month following disenrollment.

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

Sec. 62. Minnesota Statutes 2014, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above ~~200 percent of the federal poverty guidelines~~ the maximum income eligibility limit in section 256L.04, subdivision 1 or 7, 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~~ sends advance notice in accordance with Code of Federal Regulations, title 42, section 431.211, that indicates the income of a family or individual exceeds program income limits.

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

Sec. 63. Minnesota Statutes 2014, section 256L.11, subdivision 7, is amended to read:

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after ~~January 1, 2007, through August 31, 2011~~ July 1, 2016, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, ~~by 50 percent above the payment rate that would otherwise be paid to the provider.~~ ~~Effective for dental services provided on or after September 1, 2011, the commissioner shall increase the payment rate~~ by ~~30~~ 32.5 percent above the payment rate that would otherwise be paid to the provider, except for a dental clinic or dental group described in section 256B.76, subdivision 4, paragraph (b), in which the commissioner shall increase the payment rate by 30 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

Sec. 64. Minnesota Statutes 2015 Supplement, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **Premium determination for MinnesotaCare.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption applies for 12 months.

(c) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their families shall have their premiums waived by the commissioner in accordance with section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. An individual must ~~document~~ indicate status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums. The commissioner shall accept attestation of an individual's status as an American Indian as verification until the United States Department of Health and Human Services approves an electronic data source for this purpose.

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(d) For premiums effective August 1, 2015, and after, the commissioner, after consulting with the chairs and ranking minority members of the legislative committees with jurisdiction over human services, shall increase premiums under subdivision 2 for recipients based on June 2015 program enrollment. Premium increases shall be sufficient to increase projected revenue to the fund described in section 16A.724 by at least $27,800,000 for the biennium ending June 30, 2017. The commissioner shall publish the revised premium scale on the Department of Human Services Web site and in the State Register no later than June 15, 2015. The revised premium scale applies to all premiums on or after August 1, 2015, in place of the scale under subdivision 2.

(e) By July 1, 2015, the commissioner shall provide the chairs and ranking minority members of the legislative committees with jurisdiction over human services the revised premium scale effective August 1, 2015, and statutory language to codify the revised premium schedule.

(f) Premium changes authorized under paragraph (d) must only apply to enrollees not otherwise excluded from paying premiums under state or federal law. Premium changes authorized under paragraph (d) must satisfy the requirements for premiums for the Basic Health Program under title 42 of Code of Federal Regulations, section 600.505.

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

Sec. 65. Minnesota Statutes 2015 Supplement, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly 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 individual or family income.

(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).

(c) Paragraph (b) does not apply to:

(1) children 20 years of age or younger; and

(2) individuals with household incomes below 35 percent of the federal poverty guidelines.

(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

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Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
35%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$14
120%	130%	$15
130%	140%	$16
140%	150%	$25
150%	160%	$29
160%	170%	$33

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516.1	170%	180%	$38
516.2	180%	190%	$43
516.3	190%		$50

516.4 (e) The commissioner shall extend the premium scale specified in paragraph (d) to
516.5 include individuals with incomes greater than 200 percent but not exceeding 275 percent
516.6 of the federal poverty guidelines, such that individuals with incomes at 201 percent of
516.7 the federal poverty guidelines shall pay 4.09 percent of income, individuals with incomes
516.8 at 251 percent of the federal poverty guidelines shall pay 7.26 percent of income, and
516.9 individuals with incomes at 275 percent of the federal poverty guidelines shall pay 8.83
516.10 percent of income. The commissioner shall set other premium amounts in a proportional
516.11 manner using evenly spaced income steps.

516.12 **EFFECTIVE DATE.** This section is effective January 1, 2018, or upon federal
516.13 approval, whichever is later. The commissioner of human services shall notify the revisor
516.14 of statutes when federal approval is obtained.

516.15 Sec. 66. **FEDERAL WAIVER.**

516.16 Subdivision 1. **Waiver goals.** (a) The commissioner of human services, in
516.17 consultation with the commissioners of health and commerce, and the executive director
516.18 of MNsure, shall seek the necessary federal waiver authority from the United States
516.19 Department of Health and Human Services to design and operate a seamless and
516.20 sustainable health coverage continuum that reduces barriers to care, eases the transition
516.21 across the continuum for consumers, and ensures access to comprehensive and affordable
516.22 health care coverage. The waiver request shall include all proposals described in this
516.23 section and the commissioner shall seek authority to secure all federal funding available
516.24 to meet the proposals as described under this section. This includes available Medicaid
516.25 funding and all premium tax credits and cost-sharing subsidies available under United
516.26 States Code, title 26, section 36B, and United States Code, title 42, section 18071, as
516.27 applicable to each proposal.

516.28 (b) The waiver request must incorporate:

516.29 (1) the alignment of eligibility, benefits, and enrollment requirements across

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41.24 Sec. 14. Minnesota Statutes 2014, section 256L.02, is amended by adding a subdivision
41.25 to read:

41.26 Subd. 7. **Federal waiver.** The commissioner shall apply for an innovation waiver
41.27 under section 1332 of the Affordable Care Act, or any other applicable federal waiver, to
41.28 allow persons eligible for MinnesotaCare the option of declining MinnesotaCare coverage
41.29 and instead accessing advanced premium tax credits and cost-sharing reductions through
41.30 the purchase of qualified health plans through MNsure or outside of MNsure directly from
41.31 health plan companies. The commissioner shall submit this federal waiver request within
41.32 nine months of the effective date of this subdivision. The commissioner shall coordinate
41.33 this waiver request with the waiver request required by Laws 2015, chapter 71, article 12,
42.1 section 8. The commissioner shall submit a draft waiver proposal to the MNsure board and
42.2 the chairs and ranking minority members of the legislative committees with jurisdiction
42.3 over health and human services policy and finance at least 30 days before submitting a final
42.4 waiver proposal to the federal government. The commissioner shall notify the board and
42.5 the chairs and ranking minority members of any federal decision or action related to the
42.6 proposal. If federal approval is granted, the commissioner shall submit to the legislature

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insurance affordability programs, including a common income methodology, 12 months of continuous eligibility for families and children enrolled in medical assistance, consistent household composition rules, and a common definition of "American Indian";

(2) multipayer alignment across the health care coverage continuum that promotes health equity, including consistent payment methodologies across payers and products and similar coverage and contracting requirements across insurance affordability programs or product options; and

(3) innovative reforms to promote cost neutrality and sustainability, including prospective and outcome-based payment for collaborative organizations and primary care providers.

(c) In developing this federal waiver request, the commissioner shall coordinate with the appropriate state agencies and consult with stakeholder groups and consumers. The commissioner shall work with the commissioner of health for the purpose of analyzing the differences in the utilization of services and provider payment rates across markets. The commissioner may prioritize through separate waiver submissions the proposals described in paragraph (b) and subdivisions 3, 4, and 5 to the extent necessary to ensure conformity with the federal waiver application requirements.

(d) The commissioner is authorized to seek any available waivers or federal approvals to accomplish the goals and proposals under this section prior to January 1, 2018.

Subd. 2. **Expansion of the MinnesotaCare program.** (a) As part of the waiver request under subdivision 1, the commissioner shall seek authority to:

(1) expand MinnesotaCare to include persons with incomes up to 275 percent of federal poverty guidelines under section 1332 of the Affordable Care Act;

(2) modify MinnesotaCare premiums and cost-sharing to smooth affordability cliffs between insurance affordability programs; and

(3) receive for all MinnesotaCare enrollees, including but not limited to those with incomes at or below 275 percent of the federal poverty guidelines, the full amount of advanced premium tax credits, and cost-sharing reductions that these individuals would have otherwise received if they obtained qualified health plan coverage through MNsure.

(b) The commissioner shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health care finances when federal approval is obtained for this proposal.

(c) Upon federal approval, the commissioner is authorized to accept and expend federal funds that support the purpose of this subdivision.

Subd. 3. **Access to employer health coverage.** The commissioner shall include in the waiver request under subdivision 1 the ability for individuals who have access to health coverage through a spouse's or parent's employer that is deemed minimum essential

draft legislation and fiscal estimates necessary to implement the approved proposal.

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

Sec. 15. **FEDERAL-STATE ELIGIBILITY DETERMINATION AND ENROLLMENT SYSTEM FOR INSURANCE AFFORDABILITY PROGRAMS.**

Subdivision 1. **Waiver request.** (a) The commissioner of human services, in consultation with the MNsure board, commissioner of commerce, and commissioner of health, shall apply for an innovation waiver under section 1332 of the Affordable Care Act, or any other applicable federal waiver, to establish and operate a federal-state eligibility determination and enrollment system for state insurance affordability programs for coverage beginning January 1, 2018. The federal-state eligibility determination and enrollment system shall take the place of MNsure established under Minnesota Statutes, chapter 62V. Under the federal-state eligibility determination and enrollment system:

(1) eligibility determinations and enrollment for persons applying for or renewing coverage under medical assistance and MinnesotaCare shall be conducted by the commissioner of human services; and

(2) enrollment in qualified health plans and eligibility determinations for any applicable advanced premium tax credits and cost-sharing reductions shall be conducted by the federally facilitated marketplace.

(b) For purposes of this section, "state insurance affordability programs" means medical assistance, MinnesotaCare, and qualified health plan coverage with any applicable advanced premium tax credits and cost-sharing reductions.

(c) The federal-state eligibility determination and enrollment system must incorporate an asset test for adults without children who qualify for medical assistance under Minnesota Statutes, section 256B.055, subdivision 15, or MinnesotaCare under Minnesota Statutes, chapter 256L, under which a household of two or more persons must not own more than $20,000 in total net assets and a household of one person must not own more than $10,000 in total net assets.

Subd. 2. **Requirements of waiver application.** In designing the federal-state eligibility determination and enrollment system and developing the waiver application, the commissioner shall:

(1) seek to incorporate, where appropriate and cost-effective, elements of the MNsure eligibility determination system and eligibility determination systems administered by the commissioner of human services;

(2) coordinate the waiver request with the waiver requests required by Minnesota Statutes, section 256L.02, subdivision 7, if enacted, and with the waiver request required by Laws 2015, chapter 71, article 12, section 8;

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coverage under Code of Federal Regulations, title 26, section 1.36B-2, and the portion of the annual premium the employee pays for employee and dependent coverage exceeds the required contribution percentage as described in Code of Federal Regulations, title 26, section 1.36B-2, to:

(1) enroll in the MinnesotaCare program if all eligibility requirements are met, except for the eligibility requirements in Minnesota Statutes, section 256L.07, subdivision 2, paragraph (a); and

(2) be eligible for advanced premium tax credits and cost-sharing credits under Code of Federal Regulations, title 26, section 1.36B-2, as applicable to their household income when purchasing a qualified health plan through MNsure, for individuals whose income is above the maximum income eligibility limit under Minnesota Statutes, section 256L.04, subdivision 1 or 7, but less than 400 percent of federal poverty guidelines.

Subd. 4. **MinnesotaCare public option.** (a) The commissioner shall include as part of the waiver request under subdivision 1, the authority to establish a public option that allows individuals with income above the maximum income eligibility limit under Minnesota Statutes, section 256L.04, subdivision 1 or 7, and who otherwise meet the MinnesotaCare eligibility requirements to purchase coverage through MinnesotaCare instead of purchasing a qualified health plan through MNsure, or an individual health plan offered outside of MNsure. The MinnesotaCare public option shall coordinate the administration of the public option with the MinnesotaCare program to maximize efficiency and improve the continuity of care. The commissioner shall seek to implement mechanisms to ensure the long-term financial sustainability of MinnesotaCare and mitigate any adverse financial impacts to MNsure. These mechanisms must address issues related to minimizing adverse selection; the state's financial risk and contribution; and impacts to premiums in the individual and group insurance market both inside and outside of MNsure, to health care provider payment rates, and to the financial stability of urban, rural, and safety net providers.

(b) The commissioner shall also seek federal authority for individuals who qualify for the purchase option to use advanced tax credits and cost-sharing credits, if eligible, to purchase the public option and to permit the public option to be offered through MNsure to be compared with qualified health plans.

(c) The public option shall include, at a minimum, the following:

(1) establishment of an annual per enrollee premium rate similar to the average rate paid by the state to managed care plan contractors under Minnesota Statutes, section 256L.12;

(2) establishment of a benefit set equal to the benefits covered under MinnesotaCare under Minnesota Statutes, section 256L.03;

(3) limiting annual enrollment to the same annual open enrollment periods established for MNsure;

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(3) regularly consult with stakeholder groups, including but not limited to representatives of state and county agencies, health care providers, health plan companies, brokers, and consumers; and

(4) seek all available federal grants and funds for state planning and development costs.

Subd. 3. **Vendor contract; use of existing resources.** The commissioner of human services, in consultation with the chief information officer of MN.IT, may contract with a vendor to provide technical assistance in developing the waiver request. The commissioner shall develop the waiver request and enter into any contract for technical assistance using existing resources.

Subd. 4. **Reports to legislative committees.** The commissioner of human services shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services policy and finance by January 1, 2017, on progress in seeking the waiver required by this section, and shall notify these chairs and ranking minority members of any federal decision related to the waiver request.

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

(4) ability of the commissioner to adjust the purchase option's actuarial value to a value no lower than 87 percent;

(5) reimbursement mechanisms for addressing potential reductions in funding for MNsure operations; and

(6) reimbursement mechanisms for addressing potential increased cost to the MinnesotaCare program under Minnesota Statutes, chapter 256L.

(d) In preparing the actuarial analysis necessary for this portion of the waiver request, the commissioner may coordinate with the University of Minnesota School of Public Health.

Subd. 5. **Alternative open enrollment.** (a) The commissioner, in consultation with the commissioners of commerce and health, shall include in the waiver request under subdivision 1 the necessary approval to replace the annual open enrollment period in the individual health market required under the Affordable Care Act with an alternative open enrollment period for qualified health plans offered through MNsure and individual health plans offered outside of MNsure. The alternative open enrollment period must be of equal length as the existing annual open enrollment period and must not begin before the federal individual tax filing deadline.

(b) The enrollment period described in paragraph (a) shall be limited to a specific period of time. Special open enrollment periods as defined under the Affordable Care Act shall continue to apply.

Subd. 6. **Report.** On March 1, 2017, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance on the progress of receiving a federal waiver, including the results of actuarial analyses on the broader impact to the health insurance market required for waiver submission and recommendations on necessary statutory changes, including the expected fiscal impact to the state.

Subd. 7. **Implementation.** Implementation of the proposals contained in the waiver request under this section shall be contingent upon necessary federal approval, and subsequent statutory changes and state financial contributions, except for subdivision 2, which shall be effective January 1, 2018, or upon federal approval, whichever is later.

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

Sec. 67. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; NOTICE.**

For all individuals that received medical assistance non-long term care services on or after July 1, 2014, the commissioner of human services must provide notice of the 2016 amendments to Minnesota Statutes, section 256B.15, subdivisions 1a and 2. The notice must be provided within 90 days from the date of enactment.

Senate Language UEH2749-1

House Language H3467-3

Sec. 68. **REQUEST FOR INFORMATION ON A PRIVATIZED STATE-BASED MARKETPLACE MODEL.**

(a) The commissioner of management and budget, in consultation with the commissioners of human services, commerce, health, MN.IT, the executive director of MNsure, and interested stakeholders, shall develop a request for information to consider the feasibility for a private vendor to provide the technology functionality for the individual market and small business health options program (SHOP) market currently provided by MNsure. The request shall seek options for a privately run automated system and may involve existing "off-the-shelf" products or customized solutions, or both. The system must provide certain core functions including eligibility and enrollment functions, plan management, consumer outreach and assistance, and the ability for consumers to compare and choose different qualified health plans or group health plans. The system must have account transfer functionality to accept application handoffs compatible with the Medicaid and MinnesotaCare eligibility and enrollment system maintained by the Department of Human Services.

(b) The commissioner shall report to the governor and legislature the results of the request for information and an analysis of the option for a privatized marketplace, including estimated costs by December 15, 2016.

Sec. 69. **REPEALER.**

Sec. 9. **PROHIBITION ON USE OF FUNDS.**

Subdivision 1. **Use of funds.** Funding for state-sponsored health programs shall not be used for funding abortions, except to the extent necessary for continued participation in a federal program. This subdivision applies only to state-sponsored health programs that are administered by the commissioner of human services. For purposes of this section, abortion has the meaning given in Minnesota Statutes, section 144.343, subdivision 3.

Subd. 2. **Severability.** If any one or more provision, section, subdivision, sentence, clause, phrase, or word of this section or the application of it to any person or circumstance is found to be unconstitutional, it is declared to be severable and the balance of this section shall remain effective notwithstanding such unconstitutionality. The legislature intends that it would have passed this section, and each provision, section, subdivision, sentence, clause, phrase, or word irrespective of the fact that any one provision, section, subdivision, sentence, clause, phrase, or word is declared unconstitutional.

Sec. 16. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall change cross-references to sections in Minnesota Statutes and Minnesota Rules that are repealed in this article when appropriate. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text.

Sec. 17. **REPEALER.**

Senate Language UEH2749-1

(a) Minnesota Statutes 2014, section 256B.059, subdivision 1a, is repealed.

(b) Minnesota Statutes 2014, sections 256L.04, subdivisions 2a and 8; 256L.22; 256L.24; 256L.26; and 256L.28, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective June 1, 2016. Paragraph (b) is effective the day following final enactment.

House Language H3467-3

(a) Minnesota Statutes 2014, sections 62V.01; 62V.02; 62V.03, subdivisions 1 and 3; 62V.04; 62V.05, subdivisions 1, 2, 3, 4, 5, 9, and 10; 62V.06; 62V.07; 62V.08; 62V.09; 62V.10; and 62V.11, subdivisions 1, 2, and 4, are repealed.

(b) Minnesota Statutes 2015 Supplement, sections 62V.03, subdivision 2; 62V.05, subdivisions 6, 7, 8, and 11; and 62V.051, are repealed.

(c) Minnesota Rules, parts 7700.0010; 7700.0020; 7700.0030; 7700.0040; 7700.0050; 7700.0060; 7700.0070; 7700.0080; 7700.0090; 7700.0100; 7700.0101; and 7700.0105, are repealed.

EFFECTIVE DATE. This section is effective upon approval of the waiver request to establish and operate a federal-state eligibility determination and enrollment system, or January 1, 2018, whichever is later. The commissioner of human services shall notify the revisor of statutes when the waiver request is approved.