State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. 2209

04/13/2015 Authored by Laine, Bly, Liebling, Schultz, Simonson and others
The bill was read for the first time and referred to the Committee on Health and Human Services Reform

A bill for an act

relating to health; guaranteeing that all necessary health care is available and affordable for every Minnesotan; establishing the Minnesota Health Plan, Minnesota Health Board, Minnesota Health Fund, Office of Health Quality and Planning, ombudsman for patient advocacy, and auditor general for the Minnesota Health Plan; requesting a 1332 waiver; authorizing rulemaking; appropriating money; amending Minnesota Statutes 2014, sections 13.3806, by adding a subdivision; 14.03, subdivisions 2, 3; 15A.0815, subdivision 2; proposing coding for new law as Minnesota Statutes, chapter 62W.

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

ARTICLE 1

MINNESOTA HEALTH PLAN

Section 1. **[62W.01] HEALTH PLAN REQUIREMENTS.**

In order to keep Minnesota residents healthy and provide the best quality of health care, the Minnesota Health Plan must:

(1) ensure all Minnesota residents receive quality health care;

(2) not restrict, delay, or deny care or reduce the quality of care to hold down costs, but instead reduce costs through prevention, efficiency, and reduction of bureaucracy;

(3) cover all necessary care, including complete mental health services, chemical dependency treatment, prescription drugs, medical equipment and supplies, dental care, long-term care, and home care services;

(4) allow patients to choose their own providers;

(5) set premiums based on ability to pay;

(6) focus on preventive care and early intervention to improve the health of all Minnesota residents and reduce costs from untreated illnesses and diseases;

(7) ensure an adequate number of qualified health care professionals and facilities to guarantee availability of, and timely access to quality care throughout the state;

(8) continue Minnesota's leadership in medical education, training, research, and technology;

(9) provide adequate and timely payments to providers; and

(10) simplify access to health care by reducing the complexity of the funding and payment system.

Sec. 2. **[62W.02] MINNESOTA HEALTH PLAN GENERAL PROVISIONS.**

Subdivision 1. **Short title.** This chapter may be cited as the "Minnesota Health Plan."

Subd. 2. **Purpose.** The Minnesota Health Plan shall provide all medically necessary health care services for all Minnesota residents in a manner that meets the requirements in section 62W.01.

Subd. 3. **Definitions.** As used in this chapter, the following terms have the meanings provided:

(a) "Board" means the Minnesota Health Board.

(b) "Plan" means the Minnesota Health Plan.

(c) "Fund" means the Minnesota Health Fund.

(d) "Medically necessary" means services or supplies needed to promote health and to prevent, diagnose, or treat a particular patient's medical condition that meet accepted standards of medical practice within a provider's professional peer group and geographic region.

(e) "Institutional provider" means an inpatient hospital, nursing facility, rehabilitation facility, and other health care facilities that provide overnight care.

(f) "Noninstitutional provider" means individual providers, group practices, clinics, outpatient surgical centers, imaging centers, and other health facilities that do not provide overnight care.

ARTICLE 2

ELIGIBILITY

Section 1. **[62W.03] ELIGIBILITY.**

Subdivision 1. **Residency.** All Minnesota residents are eligible for the Minnesota Health Plan.

Subd. 2. **Enrollment; identification.** The Minnesota Health Board shall establish a procedure to enroll residents and provide each with identification that may be used by

health care providers to confirm eligibility for services. The application for enrollment shall be no more than two pages.

Subd. 3. **Residents temporarily out of state.** (a) The Minnesota Health Plan shall provide health care coverage to Minnesota residents who are temporarily out of the state who intend to return and reside in Minnesota.

(b) Coverage for emergency care obtained out of state shall be at prevailing local rates. Coverage for nonemergency care obtained out of state shall be according to rates and conditions established by the board. The board may require that a resident be transported back to Minnesota when prolonged treatment of an emergency condition is necessary and when that transport will not adversely affect a patient's care or condition.

Subd. 4. **Visitors.** Nonresidents visiting Minnesota shall be billed by the board for all services received under the Minnesota Health Plan. The board may enter into intergovernmental arrangements or contracts with other states and countries to provide reciprocal coverage for temporary visitors.

Subd. 5. **Nonresident employed in Minnesota.** The board shall extend eligibility to nonresidents employed in Minnesota under a premium schedule set by the board.

Subd. 6. **Business outside of Minnesota employing Minnesota residents.** The board shall apply for a federal waiver to collect the employer contribution mandated by federal law.

Subd. 7. **Retiree benefits.** (a) All persons who are eligible for retiree medical benefits under an employer-employee contract shall remain eligible for those benefits provided the contractually mandated payments for those benefits are made to the Minnesota Health Fund, which shall assume financial responsibility for care provided under the terms of the contract along with additional health benefits covered by the Minnesota Health Plan. Retirees who elect to reside outside of Minnesota shall be eligible for benefits under the terms and conditions of the retiree's employer-employee contract.

(b) The board may establish financial arrangements with states and foreign countries in order to facilitate meeting the terms of the contracts described in paragraph (a). Payments for care provided by non-Minnesota providers to Minnesota retirees shall be reimbursed at rates established by the Minnesota Health Board. Providers who accept any payment from the Minnesota Health Plan for a covered service shall not bill the patient for the covered service.

Subd. 8. **Presumptive eligibility.** (a) An individual is presumed eligible for coverage under the Minnesota Health Plan if the individual arrives at a health facility unconscious, comatose, or otherwise unable, because of the individual's physical or mental condition, to document eligibility or to act on the individual's own behalf. If the

patient is a minor, the patient is presumed eligible, and the health facility shall provide care as if the patient were eligible.

(b) Any individual is presumed eligible when brought to a health facility according to any provision of section 253B.05.

(c) Any individual involuntarily committed to an acute psychiatric facility or to a hospital with psychiatric beds according to any provision of section 253B.05, providing for involuntary commitment, is presumed eligible.

(d) All health facilities subject to state and federal provisions governing emergency medical treatment must comply with those provisions.

Subd. 9. **Data.** Data collected because an individual applies for or is enrolled in the Minnesota Health Plan are private data on individuals as defined in section 13.02, subdivision 12, but may be released to:

(1) providers for purposes of confirming enrollment and processing payments for benefits;

(2) the ombudsman for patient advocacy for purposes of performing duties under section 62W.12 or 62W.13; or

(3) the auditor general for purposes of performing duties under section 62W.14.

Sec. 2. Minnesota Statutes 2014, section 13.3806, is amended by adding a subdivision to read:

Subd. 1b. **Minnesota Health Plan.** Data on enrollees under the Minnesota Health Plan are classified under sections 62W.03, subdivision 9, and 62W.13, subdivision 6.

ARTICLE 3

BENEFITS

Section 1. **[62W.04] BENEFITS.**

Subdivision 1. **General provisions.** Any eligible individual may choose to receive services under the Minnesota Health Plan from any participating provider.

Subd. 2. **Covered benefits.** Covered health care benefits in this chapter include all medically necessary care subject to the limitations specified in subdivision 4. Covered health care benefits for Minnesota Health Plan enrollees include:

(1) inpatient and outpatient health facility services;

(2) inpatient and outpatient professional health care provider services;

(3) diagnostic imaging, laboratory services, and other diagnostic and evaluative services;

(4) medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids, their repair, technical support, and customization needed for individual use;

(5) inpatient and outpatient rehabilitative care;

(6) emergency care services;

(7) emergency transportation;

(8) necessary transportation for health care services for persons with disabilities or who may qualify as low income;

(9) child and adult immunizations and preventive care;

(10) health and wellness education;

(11) hospice care;

(12) care in a skilled nursing facility;

(13) home health care including health care provided in an assisted living facility;

(14) mental health services;

(15) substance abuse treatment;

(16) dental care;

(17) vision care;

(18) prescription drugs;

(19) podiatric care;

(20) chiropractic care;

(21) acupuncture;

(22) therapies which are shown by the National Institutes of Health National Center for Complementary and Alternative Medicine to be safe and effective;

(23) blood and blood products;

(24) dialysis;

(25) adult day care;

(26) rehabilitative and habilitative services;

(27) ancillary health care or social services previously covered by Minnesota's public health programs;

(28) case management and care coordination;

(29) language interpretation and translation for health care services, including sign language and Braille or other services needed for individuals with communication barriers; and

(30) those health care and long-term supportive services currently covered under Minnesota Statutes 2014, chapter 256B, for persons on medical assistance.

Subd. 3. **Benefit expansion.** The Minnesota Health Board may expand health care benefits beyond the minimum benefits described in this section when expansion meets the intent of this chapter and when there are sufficient funds to cover the expansion.

Subd. 4. **Cost-sharing for the room and board portion of long-term care.** The Minnesota Health Board shall develop income and asset qualifications based on medical assistance standards for covered benefits under subdivision 2, clauses (12) and (13). All health care services for long-term care in a skilled nursing facility or assisted living facility are fully covered but, notwithstanding section 62W.20, subdivision 6, room and board costs may be charged to patients who do not meet income and asset qualifications.

Subd. 5. **Exclusions.** The following health care services shall be excluded from coverage by the Minnesota Health Plan:

(1) health care services determined to have no medical benefit by the board;

(2) treatments and procedures primarily for cosmetic purposes, unless required to correct a congenital defect, restore or correct a part of the body that has been altered as a result of injury, disease, or surgery, or determined to be medically necessary by a qualified, licensed health care provider in the Minnesota Health Plan; and

(3) services of a health care provider or facility that is not licensed or accredited by the state, except for approved services provided to a Minnesota resident who is temporarily out of the state.

Subd. 6. **Prohibition.** The Minnesota Health Plan shall not pay for drugs requiring a prescription if the pharmaceutical companies directly market those drugs to consumers in Minnesota.

Sec. 2. **[62W.041] PATIENT CARE.**

(a) All patients shall have a primary care provider and have access to care coordination.

(b) Referrals are not required for a patient to see a health care specialist. If a patient sees a specialist and does not have a primary care provider, the Minnesota Health Plan may assist with choosing a primary care provider.

(c) The board may establish a computerized registry to assist patients in identifying appropriate providers.

ARTICLE 4

FUNDING

Section 1. **[62W.19] MINNESOTA HEALTH FUND.**

Subdivision 1. **General provisions.** (a) The board shall establish a Minnesota Health Fund to implement the Minnesota Health Plan and to receive premiums and other sources of revenue. The fund shall be administered by a director appointed by the Minnesota Health Board.

(b) All money collected, received, and transferred according to this chapter shall be deposited in the Minnesota Health Fund.

(c) Money deposited in the Minnesota Health Fund shall be used to finance the Minnesota Health Plan.

(d) All claims for health care services rendered shall be made to the Minnesota Health Fund.

(e) All payments made for health care services shall be disbursed from the Minnesota Health Fund.

(f) Premiums and other revenues collected each year must be sufficient to cover that year's projected costs.

Subd. 2. **Accounts.** The Minnesota Health Fund shall have operating, capital, and reserve accounts.

Subd. 3. **Operating account.** The operating account in the Minnesota Health Fund shall be comprised of the accounts specified in paragraphs (a) to (e).

(a) **Medical services account.** The medical services account must be used to provide for all medical services and benefits covered under the Minnesota Health Plan.

(b) **Prevention account.** The prevention account must be used solely to establish and maintain primary community prevention programs, including preventive screening tests.

(c) **Program administration, evaluation, planning, and assessment account.** The program administration, evaluation, planning, and assessment account must be used to monitor and improve the plan's effectiveness and operations. The board may establish grant programs including demonstration projects for this purpose.

(d) **Training and development account.** The training and development account must be used to incentivize the training and development of health care providers and the health care workforce needed to meet the health care needs of the population.

(e) **Health service research account.** The health service research account must be used to support research and innovation as determined by the Minnesota Health Board, and recommended by the Office of Health Quality and Planning and the Ombudsman for Patient Advocacy.

Subd. 4. **Capital account.** The capital account must be used solely to pay for capital expenditures for institutional providers and all capital expenditures requiring approval from the Minnesota Health Board as specified in section 62W.05, subdivision 4.

Subd. 5. **Reserve account.** (a) The Minnesota Health Plan must at all times hold in reserve an amount estimated in the aggregate to provide for the payment of all losses and claims for which the Minnesota Health Plan may be liable and to provide for the expense of adjustment or settlement of losses and claims.

(b) Money currently held in reserve by state, city, and county health programs must be transferred to the Minnesota Health Fund when the Minnesota Health Plan replaces those programs.

(c) The board shall have provisions in place to insure the Minnesota Health Plan against unforeseen expenditures or revenue shortfalls not covered by the reserve account. The board may borrow money to cover temporary shortfalls.

Sec. 2. **[62W.20] REVENUE SOURCES.**

Subdivision 1. **Minnesota Health Plan premium.** (a) The Minnesota Health Board shall:

(1) determine the aggregate cost of providing health care according to this chapter;

(2) develop an equitable and affordable premium structure based on income, including unearned income, and a business health tax based on payroll;

(3) in consultation with the Department of Revenue, develop an efficient means of collecting premiums and the business health tax; and

(4) coordinate with existing, ongoing funding sources from federal and state programs.

(b) The premium structure must be based on ability to pay.

(c) On or before January 15, 2017, the board shall submit to the governor and the legislature a report on the premium and business health tax structure established to finance the Minnesota Health Plan.

Subd. 2. **Federal receipts.** All federal funding received by Minnesota including the premium subsidies under the Affordable Care Act, Public Law 111-148, as amended by Public Law 111-152, and as authorized by the Affordable Care Act section 1332 state innovation waiver, is appropriated to the Minnesota Health Plan Board to be used only to administer the Minnesota Health Plan under chapter 62W. Federal funding that is received for implementing and administering the Minnesota Health Plan must be used only to provide comprehensive health care for all Minnesota residents.

Subd. 3. **Funds from outside sources.** Institutional providers operating under Minnesota Health Plan operating budgets may raise and expend funds from sources other than the Minnesota Health Plan including private or foundation donors. Contributions to providers in excess of $500,000 must be reported to the board.

Subd. 4. **Governmental payments.** The chief executive officer and, if required under federal law, the commissioners of health and human services shall seek all necessary waivers, exemptions, agreements, or legislation so that all current federal payments to the state including federal premiums for health care are paid directly to the Minnesota Health Plan, which shall then assume responsibility for all health care benefits and health care services previously paid for by the subsidies under the Affordable Care Act with those funds. In obtaining the waivers, exemptions, agreements, or legislation, the chief executive officer and, if required, commissioners shall seek from the federal government a contribution for health care services in Minnesota that reflects: medical inflation, the state gross domestic product, the size and age of the population, the number of residents living below the poverty level, and the number of Medicare and VA eligible individuals, and does not decrease in relation to the federal contribution to other states as a result of the waivers, exemptions, agreements, or savings from implementation of the Minnesota Health Plan.

Subd. 5. **Federal preemption.** (a) The board shall secure a repeal or a waiver of any provision of federal law that preempts any provision of this chapter. The commissioners of health and human services shall provide all necessary assistance.

(b) In the section 1332 waiver application, the board shall request to waive any of the following provisions of the Patient Protection and Affordable Care Act, to the extent necessary to implement this act:

(1) United States Code, title 42, sections 18021 to 18024;

(2) United States Code, title 42, sections 18031 to 18033;

(3) United States Code, title 42, section 18071; and

(4) sections 36B and 5000A of the Internal Revenue Code of 1986, as amended.

(c) In the event that a repeal or a waiver of law or regulations cannot be secured, the board shall adopt rules, or seek conforming state legislation, consistent with federal law, in an effort to best fulfill the purposes of this chapter.

(d) The Minnesota Health Plan's responsibility for providing care shall be secondary to existing federal government programs for health care services to the extent that funding for these programs is not transferred to the Minnesota Health Fund or that the transfer is delayed beyond the date on which initial benefits are provided under the Minnesota Health Plan.

Subd. 6. **No cost-sharing.** No deductible, co-payment, coinsurance, or other cost-sharing shall be imposed with respect to covered benefits.

Sec. 3. **[62W.21] SUBROGATION.**

Subdivision 1. **Collateral source.** (a) When other payers for health care have been terminated, health care costs shall be collected from collateral sources whenever medical services provided to an individual are, or may be, covered services under a policy of insurance, or other collateral source available to that individual, or when the individual has a right of action for compensation permitted under law.

(b) As used in this section, collateral source includes:

(1) health insurance policies and the medical components of automobile, homeowners, and other forms of insurance;

(2) medical components of worker's compensation;

(3) pension plans;

(4) employer plans;

(5) employee benefit contracts;

(6) government benefit programs;

(7) a judgment for damages for personal injury;

(8) the state of last domicile for individuals moving to Minnesota for medical care who have extraordinary medical needs; and

(9) any third party who is or may be liable to an individual for health care services or costs.

(c) Collateral source does not include:

(1) a contract or plan that is subject to federal preemption; or

(2) any governmental unit, agency, or service, to the extent that subrogation is prohibited by law. An entity described in paragraph (b) is not excluded from the obligations imposed by this section by virtue of a contract or relationship with a government unit, agency, or service.

(d) The board shall negotiate waivers, seek federal legislation, or make other arrangements to incorporate collateral sources into the Minnesota Health Plan.

Subd. 2. **Collateral source; negotiation.** When an individual who receives health care services under the Minnesota Health Plan is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, the individual shall notify the health care provider and provide information identifying the collateral source, the nature and extent of coverage or entitlement, and other relevant information. The health care provider shall forward this information to the board. The individual entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source shall provide additional information as requested by the board.

Subd. 3. **Reimbursement.** (a) The Minnesota Health Plan shall seek reimbursement from the collateral source for services provided to the individual and may institute

appropriate action, including legal proceedings, to recover the reimbursement. Upon demand, the collateral source shall pay to the Minnesota Health Fund the sums it would have paid or expended on behalf of the individual for the health care services provided by the Minnesota Health Plan.

(b) In addition to any other right to recovery provided in this section, the board shall have the same right to recover the reasonable value of health care benefits from a collateral source as provided to the commissioner of human services under section 256B.37.

(c) If a collateral source is exempt from subrogation or the obligation to reimburse the Minnesota Health Plan, the board may require that an individual who is entitled to medical services from the source first seek those services from that source before seeking those services from the Minnesota Health Plan.

(d) To the extent permitted by federal law, the board shall have the same right of subrogation over contractual retiree health care benefits provided by employers as other contracts, allowing the Minnesota Health Plan to recover the cost of health care services provided to individuals covered by the retiree benefits, unless arrangements are made to transfer the revenues of the health care benefits directly to the Minnesota Health Plan.

Subd. 4. **Defaults, underpayments, and late payments.** (a) Default, underpayment, or late payment of any tax or other obligation imposed by this chapter shall result in the remedies and penalties provided by law, except as provided in this section.

(b) Eligibility for health care benefits under section 62W.04 shall not be impaired by any default, underpayment, or late payment of any premium or other obligation imposed by this chapter.

ARTICLE 5

PAYMENTS

Section 1. **[62W.05] PROVIDER PAYMENTS.**

Subdivision 1. **General provisions.** (a) All health care providers licensed to practice in Minnesota may participate in the Minnesota Health Plan and other providers as determined by the board.

(b) A participating health care provider shall comply with all federal laws and regulations governing referral fees and fee splitting including, but not limited to, United States Code, title 42, sections 1320a-7b and 1395nn, whether reimbursed by federal funds or not.

(c) A fee schedule or financial incentive may not adversely affect the care a patient receives or the care a health provider recommends.

Subd. 2. **Payments to noninstitutional providers.** (a) The Minnesota Health Board shall establish and oversee a payment system for noninstitutional providers that promotes quality and controls cost.

(b) The board shall pay noninstitutional providers based on rates negotiated with providers. Rates shall take into account the need to address provider shortages.

(c) The board shall establish payment criteria and methods of payment for care coordination for patients especially those with chronic illness and complex medical needs.

(d) Providers who accept any payment from the Minnesota Health Plan for a covered health care service shall not bill the patient for the covered health care service.

(e) Providers shall be paid within 30 business days for claims filed following procedures established by the board.

Subd. 3. **Payments to institutional providers.** (a) The board shall establish annual budgets for institutional providers. These budgets shall consist of an operating and a capital budget. An institution's annual budget shall be negotiated to cover its anticipated health care services for the next year based on past performance and projected changes in prices and health care service levels.

(b) Providers who accept any payment from the Minnesota Health Plan for a covered health care service shall not bill the patient for the covered health care service.

Subd. 4. **Capital management plan.** (a) The board shall periodically develop a capital investment plan that will serve as a guide in determining the annual budgets of institutional providers and in deciding whether to approve applications for approval of capital expenditures by noninstitutional providers.

(b) Providers who propose to make capital purchases in excess of $500,000 must obtain board approval. The board may alter the threshold expenditure level that triggers the requirement to submit information on capital expenditures. Institutional providers shall propose these expenditures and submit the required information as part of the annual budget they submit to the board. Noninstitutional providers shall submit applications for approval of these expenditures to the board. The board must respond to capital expenditure applications in a timely manner.

ARTICLE 6

GOVERNANCE

Section 1. Minnesota Statutes 2014, section 14.03, subdivision 2, is amended to read:

Subd. 2. **Contested case procedures.** The contested case procedures of the Administrative Procedure Act provided in sections 14.57 to 14.69 do not apply to (a) proceedings under chapter 414, except as specified in that chapter, (b) the commissioner of

corrections, (c) the unemployment insurance program and the Social Security disability determination program in the Department of Employment and Economic Development, (d) the commissioner of mediation services, (e) the Workers' Compensation Division in the Department of Labor and Industry, (f) the Workers' Compensation Court of Appeals, ~~or~~ (g) the Board of Pardons, or (h) the Minnesota Health Plan.

Sec. 2. Minnesota Statutes 2014, section 15A.0815, subdivision 2, is amended to read:

Subd. 2. **Group I salary limits.** The salary for a position listed in this subdivision shall not exceed 133 percent of the salary of the governor. This limit must be adjusted annually on January 1. The new limit must equal the limit for the prior year increased by the percentage increase, if any, in the Consumer Price Index for all urban consumers from October of the second prior year to October of the immediately prior year. The commissioner of management and budget must publish the limit on the department's Web site. This subdivision applies to the following positions:

Commissioner of administration;

Commissioner of agriculture;

Commissioner of education;

Commissioner of commerce;

Commissioner of corrections;

Commissioner of health;

Chief executive officer of the Minnesota Health Plan;

Commissioner, Minnesota Office of Higher Education;

Commissioner, Housing Finance Agency;

Commissioner of human rights;

Commissioner of human services;

Commissioner of labor and industry;

Commissioner of management and budget;

Commissioner of natural resources;

Commissioner, Pollution Control Agency;

Executive director, Public Employees Retirement Association;

Commissioner of public safety;

Commissioner of revenue;

Executive director, State Retirement System;

Executive director, Teachers Retirement Association;

Commissioner of employment and economic development;

Commissioner of transportation; and

Commissioner of veterans affairs.

Sec. 3. **[62W.06] MINNESOTA HEALTH BOARD.**

Subdivision 1. **Establishment.** The Minnesota Health Board is established to promote the delivery of high quality, coordinated health care services that enhance health; prevent illness, disease, and disability; slow the progression of chronic diseases; and improve personal health management. The board shall administer the Minnesota Health Plan. The board shall oversee:

(1) the Office of Health Quality and Planning under section 62W.09; and

(2) the Minnesota Health Fund under section 62W.19.

Subd. 2. **Board composition.** The board shall consist of 15 members, including a representative selected by each of the five rural regional health planning boards under section 62W.08 and three representatives selected by the metropolitan regional health planning board under section 62W.08. These members shall select the following:

(1) one patient member and one employer member appointed by the board members; and

(2) five providers appointed by the board members that include one physician, one registered nurse, one mental health provider, one dentist, and one facility director.

Subd. 3. **Term and compensation; selection of chair.** Board members shall serve four years. Board members shall set the board's compensation not to exceed the compensation of Public Utilities Commission members. The board shall select the chair from its membership.

Subd. 4. **General duties.** The board shall:

(1) ensure that all of the requirements of section 62W.01 are met;

(2) hire a chief executive officer for the Minnesota Health Plan to administer all aspects of the plan as directed by the board;

(3) hire a director for the Office of Health Quality and Planning;

(4) hire a director of the Minnesota Health Fund;

(5) provide technical assistance to the regional boards established under section 62W.08;

(6) conduct necessary investigations and inquiries and require the submission of information, documents, and records the board considers necessary to carry out the purposes of this chapter;

(7) establish a process for the board to receive the concerns, opinions, ideas, and recommendations of the public regarding all aspects of the Minnesota Health Plan and the means of addressing those concerns;

(8) conduct other activities the board considers necessary to carry out the purposes of this chapter;

(9) collaborate with the agencies that license health facilities to ensure that facility performance is monitored and that deficient practices are recognized and corrected in a timely manner;

(10) adopt rules as necessary to carry out the duties assigned under this chapter;

(11) establish conflict of interest standards prohibiting providers from any financial benefit from their medical decisions outside of board reimbursement;

(12) establish conflict of interest standards related to pharmaceutical marketing to providers; and

(13) provide financial help and assistance in retraining and job placement to Minnesota workers who may be displaced because of the administrative efficiencies of the Minnesota Health Plan.

There is currently a serious shortage of providers in many health care professions, from medical technologists to registered nurses, and many potentially displaced health administrative workers already have training in some medical field. To alleviate these shortages, the dislocated worker support program should emphasize retraining and placement into health care related positions if appropriate. As Minnesota residents, all displaced workers shall be covered under the Minnesota Health Plan.

Subd. 5. **Waiver request duties.** Before submitting a waiver application under section 1332 of the Patient Protection and Affordable Care Act, Public Law Number 111-148, as amended, the board shall do the following, as required by federal law:

(1) conduct or contract for any necessary actuarial analyses and actuarial certifications needed to support the board's estimates that the waiver will comply with the comprehensive coverage, affordability, and scope of coverage requirements in federal law;

(2) conduct or contract for any necessary economic analyses needed to support the board's estimates that the waiver will comply with the comprehensive coverage, affordability, scope of coverage, and federal deficit requirements in federal law. These analyses must include:

(i) a detailed ten-year budget plan; and

(ii) a detailed analysis regarding the estimated impact of the waiver on health insurance coverage in the state;

(3) establish a detailed draft implementation timeline for the waiver plan; and

(4) establish quarterly, annual, and cumulative targets for the comprehensive coverage, affordability, scope of coverage, and federal deficit requirements in federal law.

Subd. 6. **Financial duties.** The board shall:

(1) establish and collect premiums and the business health tax according to section 62W.20, subdivision 1;

(2) approve statewide and regional budgets that include budgets for the accounts in section 62W.19;

(3) negotiate and establish payment rates for providers;

(4) monitor compliance with all budgets and payment rates and take action to achieve compliance to the extent authorized by law;

(5) pay claims for medical products or services as negotiated, and may issue requests for proposals from Minnesota nonprofit business corporations for a contract to process claims;

(6) seek federal approval to bill other states for health care coverage provided to residents from out-of-state who come to Minnesota for long-term care or other costly treatment when the resident's home state fails to provide such coverage, unless a reciprocal agreement with those states to provide similar coverage to Minnesota residents relocating to those states can be negotiated;

(7) administer the Minnesota Health Fund created under section 62W.19;

(8) annually determine the appropriate level for the Minnesota Health Plan reserve account and implement policies needed to establish the appropriate reserve;

(9) implement fraud prevention measures necessary to protect the operation of the Minnesota Health Plan; and

(10) work to ensure appropriate cost control by:

(i) instituting aggressive public health measures, early intervention and preventive care, health and wellness education, and promotion of personal health improvement;

(ii) making changes in the delivery of health care services and administration that improve efficiency and care quality;

(iii) minimizing administrative costs;

(iv) ensuring that the delivery system does not contain excess capacity; and

(v) negotiating the lowest possible prices for prescription drugs, medical equipment, and medical services.

If the board determines that there will be a revenue shortfall despite the cost control measures mentioned in clause (10), the board shall implement measures to correct the shortfall, including an increase in premiums and other revenues. The board shall report to the legislature on the causes of the shortfall, reasons for the inadequacy of cost controls, and measures taken to correct the shortfall.

Subd. 7. **Minnesota Health Board management duties.** The board shall:

(1) develop and implement enrollment procedures for the Minnesota Health Plan;

(2) implement eligibility standards for the Minnesota Health Plan;

(3) arrange for health care to be provided at convenient locations, including ensuring the availability of school nurses so that all students have access to health care, immunizations, and preventive care at public schools and encouraging providers to open small health clinics at larger workplaces and retail centers;

(4) make recommendations, when needed, to the legislature about changes in the geographic boundaries of the health planning regions;

(5) establish an electronic claims and payments system for the Minnesota Health Plan;

(6) monitor the operation of the Minnesota Health Plan through consumer surveys and regular data collection and evaluation activities, including evaluations of the adequacy and quality of services furnished under the program, the need for changes in the benefit package, the cost of each type of service, and the effectiveness of cost control measures under the program;

(7) disseminate information and establish a health care Web site to provide information to the public about the Minnesota Health Plan including providers and facilities, and state and regional health planning board meetings and activities;

(8) collaborate with public health agencies, schools, and community clinics;

(9) ensure that Minnesota Health Plan policies and providers, including public health providers, support all Minnesota residents in achieving and maintaining maximum physical and mental health; and

(10) annually report to the chairs and ranking minority members of the senate and house of representatives committees with jurisdiction over health care issues on the performance of the Minnesota Health Plan, fiscal condition and need for payment adjustments, any needed changes in geographic boundaries of the health planning regions, recommendations for statutory changes, receipt of revenue from all sources, whether current year goals and priorities are met, future goals and priorities, major new technology or prescription drugs, and other circumstances that may affect the cost or quality of health care.

Subd. 8. **Policy duties.** The board shall:

(1) develop and implement cost control and quality assurance procedures;

(2) ensure strong public health services including education and community prevention and clinical services;

(3) ensure a continuum of coordinated high-quality primary to tertiary care to all Minnesota residents; and

(4) implement policies to ensure that all Minnesota residents receive culturally and linguistically competent care.

Subd. 9. **Self-insurance.** The board shall determine the feasibility of self-insuring providers for malpractice and shall establish a self-insurance system and create a special fund for payment of losses incurred if the board determines self-insuring providers would reduce costs.

Sec. 4. **[62W.07] HEALTH PLANNING REGIONS.**

A metropolitan health planning region consisting of the seven-county metropolitan area is established. By October 1, 2016, the commissioner of health shall designate five rural health planning regions from the greater Minnesota area composed of geographically contiguous counties grouped on the basis of the following considerations:

(1) patterns of utilization of health care services;

(2) health care resources, including workforce resources;

(3) health needs of the population, including public health needs;

(4) geography;

(5) population and demographic characteristics; and

(6) other considerations as appropriate.

The commissioner of health shall designate the health planning regions.

Sec. 5. **[62W.08] REGIONAL HEALTH PLANNING BOARD.**

Subdivision 1. **Regional planning board composition.** (a) Each regional board shall consist of one county commissioner per county selected by the county board and two county commissioners per county selected by the county board in the seven-county metropolitan area. A county commissioner may designate a representative to act as a member of the board in the member's absence. Each board shall select the chair from among its membership.

(b) Board members shall serve for four-year terms and may receive per diems for meetings as provided in section 15.059, subdivision 3.

Subd. 2. **Regional health board duties.** Regional health planning boards shall:

(1) recommend health standards, goals, priorities, and guidelines for the region;

(2) prepare an operating and capital budget for the region to recommend to the Minnesota Health Board;

(3) collaborate with local public health care agencies to educate consumers and providers on public health programs, goals, and the means of reaching those goals;

(4) hire a regional health planning director;

(5) collaborate with public health care agencies to implement public health and wellness initiatives; and

(6) ensure that all parts of the region have access to a 24-hour nurse hotline and 24-hour urgent care clinics.

Sec. 6. **[62W.09] OFFICE OF HEALTH QUALITY AND PLANNING.**

Subdivision 1. **Establishment.** The Minnesota Health Board shall establish an Office of Health Quality and Planning to assess the quality, access, and funding adequacy of the Minnesota Health Plan.

Subd. 2. **General duties.** (a) The Office of Health Quality and Planning shall make annual recommendations to the board on the overall direction on subjects including:

(1) the overall effectiveness of the Minnesota Health Plan in addressing public health and wellness;

(2) access to health care;

(3) quality improvement;

(4) efficiency of administration;

(5) adequacy of budget and funding;

(6) appropriateness of payments for providers;

(7) capital expenditure needs;

(8) long-term health care;

(9) mental health and substance abuse services;

(10) staffing levels and working conditions in health care facilities;

(11) identification of number and mix of health care facilities and providers required to best meet the needs of the Minnesota Health Plan;

(12) care for chronically ill patients;

(13) educating providers on promoting the use of advance directives with patients to enable patients to obtain the health care of their choice;

(14) research needs; and

(15) integration of disease management programs into health care delivery.

(b) Analyze shortages in health care workforce required to meet the needs of the population and develop plans to meet those needs in collaboration with regional planners and educational institutions.

(c) Analyze methods of paying providers and make recommendations to improve quality and control costs.

(d) Assist in coordination of the Minnesota Health Plan and public health programs.

Subd. 3. **Assessment and evaluation of benefits.** (a) The Office of Health Quality and Planning shall:

(1) consider health care benefit additions to the Minnesota Health Plan and evaluate them based on evidence of clinical efficacy;

(2) establish a process and criteria by which providers may request authorization to provide health care services and treatments that are not included in the Minnesota Health Plan benefit set, including experimental health care treatments;

(3) evaluate proposals to increase the efficiency and effectiveness of the health care delivery system, and make recommendations to the board based on the cost-effectiveness of the proposals; and

(4) identify complementary and alternative health care modalities that have been shown to be safe and effective.

(b) The board may convene advisory panels as needed.

Sec. 7. **[62W.10] ETHICS AND CONFLICT OF INTEREST.**

(a) All provisions of section 43A.38 apply to employees and the chief executive officer of the Minnesota Health Plan, the members and directors of the Minnesota Health Board, the regional health boards, the director of the Office of Health Quality and Planning, the director of the Minnesota Health Fund, and the ombudsman for patient advocacy. Failure to comply with section 43A.38 shall be grounds for disciplinary action which may include termination of employment or removal from the board.

(b) In order to avoid the appearance of political bias or impropriety, the Minnesota Health Plan chief executive officer shall not:

(1) engage in leadership of, or employment by, a political party or a political organization;

(2) publicly endorse a political candidate;

(3) contribute to any political candidates or political parties and political organizations; or

(4) attempt to avoid compliance with this subdivision by making contributions through a spouse or other family member.

(c) In order to avoid a conflict of interest, individuals specified in paragraph (a) shall not be currently employed by a medical provider or a pharmaceutical, medical insurance, or medical supply company. This paragraph does not apply to the five provider members of the board.

Sec. 8. **[62W.11] CONFLICT OF INTEREST COMMITTEE.**

(a) The board shall establish a conflict of interest committee to develop standards of practice for individuals or entities doing business with the Minnesota Health Plan,

including but not limited to, board members, providers, and medical suppliers. The committee shall establish guidelines on the duty to disclose the existence of a financial interest and all material facts related to that financial interest to the committee.

(b) In considering the transaction or arrangement, if the committee determines a conflict of interest exists, the committee shall investigate alternatives to the proposed transaction or arrangement. After exercising due diligence, the committee shall determine whether the Minnesota Health Plan can obtain with reasonable efforts a more advantageous transaction or arrangement with a person or entity that would not give rise to a conflict of interest. If this is not reasonably possible under the circumstances, the committee shall make a recommendation to the board on whether the transaction or arrangement is in the best interest of the Minnesota Health Plan, and whether the transaction is fair and reasonable. The committee shall provide the board with all material information used to make the recommendation. After reviewing all relevant information, the board shall decide whether to approve the transaction or arrangement.

Sec. 9. **[62W.12] OMBUDSMAN OFFICE FOR PATIENT ADVOCACY.**

Subdivision 1. **Creation of office; generally.** (a) The Ombudsman Office for Patient Advocacy is created to represent the interests of the consumers of health care. The ombudsman shall help residents of the state secure the health care services and health care benefits they are entitled to under the laws administered by the Minnesota Health Board and advocate on behalf of and represent the interests of enrollees in entities created by this chapter and in other forums.

(b) The ombudsman shall be a patient advocate appointed by the governor, who serves in the unclassified service and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be knowledgeable about and have experience in health care services and administration.

(c) The ombudsman may gather information about decisions, acts, and other matters of the Minnesota Health Board, health care organization, or a health care program. A person may not serve as ombudsman while holding another public office.

(d) The budget for the ombudsman's office shall be determined by the legislature and is independent from the Minnesota Health Board. The ombudsman shall establish offices to provide convenient access to residents.

(e) The Minnesota Health Board has no oversight or authority over the ombudsman for patient advocacy.

Subd. 2. **Ombudsman's duties.** The ombudsman shall:

(1) ensure that patient advocacy services are available to all Minnesota residents;

(2) establish and maintain the grievance process according to section 62W.13;

(3) receive, evaluate, and respond to consumer complaints about the Minnesota Health Plan;

(4) establish a process to receive recommendations from the public about ways to improve the Minnesota Health Plan;

(5) develop educational and informational guides according to communication services under section 15.441, describing consumer rights and responsibilities;

(6) ensure the guides in clause (5) are widely available to consumers and specifically available in provider offices and health care facilities; and

(7) prepare an annual report about the consumer perspective on the performance of the Minnesota Health Plan, including recommendations for needed improvements.

Sec. 10. **[62W.13] GRIEVANCE SYSTEM.**

Subdivision 1. **Grievance system established.** The ombudsman shall establish a grievance system for all complaints. The system shall provide a process that ensures adequate consideration of Minnesota Health Plan enrollee grievances and appropriate remedies.

Subd. 2. **Referral of grievances.** The ombudsman may refer any grievance that does not pertain to compliance with this chapter to the federal Centers for Medicare and Medicaid Services or any other appropriate local, state, and federal government entity for investigation and resolution.

Subd. 3. **Submittal by designated agents and providers.** A provider may join with, or otherwise assist, a complainant to submit the grievance to the ombudsman. A provider or an employee of a provider who, in good faith, joins with or assists a complainant in submitting a grievance is subject to the protections and remedies under sections 181.931 to 181.935.

Subd. 4. **Review of documents.** The ombudsman may require additional information from health care providers or the board.

Subd. 5. **Written notice of disposition.** The ombudsman shall send a written notice of the final disposition of the grievance, and the reasons for the decision, to the complainant, to any provider who is assisting the complainant, and to the board, within 30 calendar days of receipt of the request for review unless the ombudsman determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. The ombudsman's order of corrective action shall be binding on the Minnesota Health Plan. A decision of the ombudsman is subject to de novo review by the district court.

Subd. 6. **Data.** Data on enrollees collected because an enrollee submits a complaint to the ombudsman are private data on individuals as defined in section 13.02, subdivision 12, but may be released to a provider who is the subject of the complaint or to the board for purposes of this section.

Sec. 11. **[62W.14] AUDITOR GENERAL FOR THE MINNESOTA HEALTH PLAN.**

Subdivision 1. **Establishment.** There is within the Office of the Legislative Auditor an auditor general for health care fraud and abuse for the Minnesota Health Plan who is appointed by the legislative auditor.

Subd. 2. **Duties.** The auditor general shall:

(1) investigate, audit, and review the financial and business records of individuals, public and private agencies and institutions, and private corporations that provide services or products to the Minnesota Health Plan, the costs of which are reimbursed by the Minnesota Health Plan;

(2) investigate allegations of misconduct on the part of an employee or appointee of the Minnesota Health Board and on the part of any provider of health care services that is reimbursed by the Minnesota Health Plan, and report any findings of misconduct to the attorney general;

(3) investigate fraud and abuse;

(4) arrange for the collection and analysis of data needed to investigate the inappropriate utilization of these products and services; and

(5) annually report recommendations for improvements to the Minnesota Health Plan to the board.

Sec. 12. **[62W.15] MINNESOTA HEALTH PLAN POLICIES AND PROCEDURES; RULEMAKING.**

Subdivision 1. **Exempt rules.** The Minnesota Health Plan policies and procedures are exempt from the Administrative Procedure Act but, to the extent authorized by law to adopt rules, the board may use the provisions of section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to these rules.

Subd. 2. **Rulemaking procedures.** (a) Whenever the board determines that a rule should be adopted under this section establishing, modifying, or revoking a policy or procedure, the board shall publish in the State Register the proposed policy or procedure and shall afford interested persons a period of 30 days after publication to submit written data or comments.

(b) On or before the last day of the period provided for the submission of written data or comments, any interested person may file with the board written objections to the proposed rule, stating the grounds for objection and requesting a public hearing on those objections. Within 30 days after the last day for filing objections, the board shall publish in the State Register a notice specifying the policy or procedure to which objections have been filed and a hearing requested and specifying a time and place for the hearing.

Subd. 3. **Rule adoption.** Within 60 days after the expiration of the period provided for the submission of written data or comments, or within 60 days after the completion of any hearing, the board shall issue a rule adopting, modifying, or revoking a policy or procedure, or make a determination that a rule should not be adopted. The rule may contain a provision delaying its effective date for such period as the board determines is necessary.

Sec. 13. Minnesota Statutes 2014, section 14.03, subdivision 3, is amended to read:

Subd. 3. **Rulemaking procedures.** (a) The definition of a rule in section 14.02, subdivision 4, does not include:

(1) rules concerning only the internal management of the agency or other agencies that do not directly affect the rights of or procedures available to the public;

(2) an application deadline on a form; and the remainder of a form and instructions for use of the form to the extent that they do not impose substantive requirements other than requirements contained in statute or rule;

(3) the curriculum adopted by an agency to implement a statute or rule permitting or mandating minimum educational requirements for persons regulated by an agency, provided the topic areas to be covered by the minimum educational requirements are specified in statute or rule;

(4) procedures for sharing data among government agencies, provided these procedures are consistent with chapter 13 and other law governing data practices.

(b) The definition of a rule in section 14.02, subdivision 4, does not include:

(1) rules of the commissioner of corrections relating to the release, placement, term, and supervision of inmates serving a supervised release or conditional release term, the internal management of institutions under the commissioner's control, and rules adopted under section 609.105 governing the inmates of those institutions;

(2) rules relating to weight limitations on the use of highways when the substance of the rules is indicated to the public by means of signs;

(3) opinions of the attorney general;

(4) the data element dictionary and the annual data acquisition calendar of the Department of Education to the extent provided by section 125B.07;

(5) the occupational safety and health standards provided in section 182.655;

(6) revenue notices and tax information bulletins of the commissioner of revenue;

(7) uniform conveyancing forms adopted by the commissioner of commerce under section 507.09;

(8) standards adopted by the Electronic Real Estate Recording Commission established under section 507.0945; ~~or~~

(9) the interpretive guidelines developed by the commissioner of human services to the extent provided in chapter 245A.~~;~~ or

(10) policies and procedures adopted by the Minnesota Health Board under chapter 62W.

ARTICLE 7

IMPLEMENTATION

Section 1. **APPROPRIATION.**

$..... is appropriated in fiscal year 2016 from the general fund to the Minnesota Health Fund under the Minnesota Health Plan to provide start-up funding for the provisions of this act.

Sec. 2. **EFFECTIVE DATE AND TRANSITION.**

Subdivision 1. **Notice and effective date.** This act is effective the day following final enactment. The commissioner of management and budget shall notify the chairs of the house of representatives and senate committees with jurisdiction over health care when the Minnesota Health Fund has sufficient revenues to fund the costs of implementing this act.

Subd. 2. **Timing to implement.** The Minnesota Health Plan must be operational within two years from the date of final enactment of this act.

Subd. 3. **Prohibition.** On and after the day the Minnesota Health Plan becomes operational, a health plan, as defined in Minnesota Statutes, section 62Q.01, subdivision 3, may not be sold in Minnesota for services provided by the Minnesota Health Plan.

Subd. 4. **Transition.** (a) The commissioners of health and human services shall prepare an analysis of the state's capital expenditure needs for the purpose of assisting the board in adopting the statewide capital budget for the year following implementation. The commissioners shall submit this analysis to the board.

(b) The following timelines shall be implemented:

(1) the commissioner of health shall designate the health planning regions utilizing the criteria specified in Minnesota Statutes, section 62W.07, three months after the date of enactment of this act;

(2) the regional boards shall be established six months after the date of enactment of this act; and

(3) the Minnesota Health Board shall be established nine months after the date of enactment of this act; and

(4) the commissioner of health, or the commissioner's designee, shall convene the first meeting of each of the regional boards and the Minnesota Health Board within 30 days after each of the boards has been established.

APPENDIX
Article locations in 15-4126