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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. **2211**

04/13/2015 Authored by Dean, M.,
The bill was read for the first time and referred to the Committee on Taxes

1.1 A bill for an act
1.2 relating to taxes; establishing a state tax credit for MNsure premium
1.3 payments; repealing the MinnesotaCare program; advancing the repeal date for
1.4 MinnesotaCare provider taxes; amending Minnesota Statutes 2014, sections
1.5 62V.05, subdivision 5; 256.98, subdivision 1; 256B.021, subdivision 4; 270A.03,
1.6 subdivision 5; 270B.14, subdivision 1; Laws 2011, First Special Session chapter
1.7 9, article 6, section 97, subdivision 6; proposing coding for new law in Minnesota
1.8 Statutes, chapter 290; repealing Minnesota Statutes 2014, sections 13.461,
1.9 subdivision 26; 16A.724, subdivision 3; 62A.046, subdivision 5; 256L.01,
1.10 subdivisions 1, 1a, 1b, 2, 3, 3a, 5, 6, 7; 256L.02, subdivisions 1, 2, 3, 5, 6;
1.11 256L.03, subdivisions 1, 1a, 1b, 2, 3, 3a, 3b, 4, 4a, 5, 6; 256L.04, subdivisions
1.12 1, 1a, 1c, 2, 2a, 7, 7a, 7b, 8, 10, 12, 13, 14; 256L.05, subdivisions 1, 1a, 1b,
1.13 1c, 2, 3, 3a, 3c, 4, 5, 6; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3,
1.14 4; 256L.09, subdivisions 1, 2, 4, 5, 6, 7; 256L.10; 256L.11, subdivisions 1, 2,
1.15 2a, 3, 4, 7; 256L.12; 256L.121; 256L.15, subdivisions 1, 1a, 1b, 2; 256L.18;
1.16 256L.22; 256L.24; 256L.26; 256L.28.

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

1.18 **ARTICLE 1**

1.19 **STATE TAX CREDIT**

1.20 Section 1. Minnesota Statutes 2014, section 62V.05, subdivision 5, is amended to read:

1.21 **Subd. 5. Health carrier and health plan requirements; participation.** (a)

1.22 Beginning January 1, 2015, the board may establish certification requirements for health
1.23 carriers and health plans to be offered through MNsure that satisfy federal requirements
1.24 under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148.

1.25 (b) Paragraph (a) does not apply if by June 1, 2013, the legislature enacts regulatory
1.26 requirements that:

1.27 (1) apply uniformly to all health carriers and health plans in the individual market;

2.1 (2) apply uniformly to all health carriers and health plans in the small group market;
2.2 and

2.3 (3) satisfy minimum federal certification requirements under section 1311(c)(1) of
2.4 the Affordable Care Act, Public Law 111-148.

2.5 (c) In accordance with section 1311(e) of the Affordable Care Act, Public Law
2.6 111-148, the board shall establish policies and procedures for certification and selection
2.7 of health plans to be offered as qualified health plans through MNsure. The board shall
2.8 certify and select a health plan as a qualified health plan to be offered through MNsure, if:

2.9 (1) the health plan meets the minimum certification requirements established in
2.10 paragraph (a) or the market regulatory requirements in paragraph (b);

2.11 (2) the board determines that making the health plan available through MNsure is in
2.12 the interest of qualified individuals and qualified employers;

2.13 (3) the health carrier applying to offer the health plan through MNsure also applies
2.14 to offer health plans at each actuarial value level and service area that the health carrier
2.15 currently offers in the individual and small group markets; and

2.16 (4) the health carrier does not apply to offer health plans in the individual and
2.17 small group markets through MNsure under a separate license of a parent organization
2.18 or holding company under section 60D.15, that is different from what the health carrier
2.19 offers in the individual and small group markets outside MNsure.

2.20 (d) In determining the interests of qualified individuals and employers under
2.21 paragraph (c), clause (2), the board may not exclude a health plan for any reason specified
2.22 under section 1311(e)(1)(B) of the Affordable Care Act, Public Law 111-148. The board
2.23 may consider:

2.24 (1) affordability;

2.25 (2) quality and value of health plans;

2.26 (3) promotion of prevention and wellness;

2.27 (4) promotion of initiatives to reduce health disparities;

2.28 (5) market stability and adverse selection;

2.29 (6) meaningful choices and access;

2.30 (7) alignment and coordination with state agency and private sector purchasing
2.31 strategies and payment reform efforts; and

2.32 (8) other criteria that the board determines appropriate.

2.33 (e) For qualified health plans offered through MNsure on or after January 1, 2015,
2.34 the board shall establish policies and procedures under paragraphs (c) and (d) for selection
2.35 of health plans to be offered as qualified health plans through MNsure by February 1
2.36 of each year, beginning February 1, 2014. The board shall consistently and uniformly

3.1 apply all policies and procedures and any requirements, standards, or criteria to all health
 3.2 carriers and health plans. For any policies, procedures, requirements, standards, or criteria
 3.3 that are defined as rules under section 14.02, subdivision 4, the board may use the process
 3.4 described in subdivision 9.

3.5 (f) For 2014, the board shall not have the power to select health carriers and health
 3.6 plans for participation in MNsure. The board shall permit all health plans that meet the
 3.7 certification requirements under section 1311(c)(1) of the Affordable Care Act, Public
 3.8 Law 111-148, to be offered through MNsure.

3.9 (g) Under this subdivision, the board shall have the power to verify that health
 3.10 carriers and health plans are properly certified to be eligible for participation in MNsure.

3.11 (h) The board has the authority to decertify health carriers and health plans that
 3.12 fail to maintain compliance with section 1311(c)(1) of the Affordable Care Act, Public
 3.13 Law 111-148.

3.14 (i) For qualified health plans offered through MNsure beginning January 1, 2015,
 3.15 health carriers must use the most current addendum for Indian health care providers
 3.16 approved by the Centers for Medicare and Medicaid Services and the tribes as part of their
 3.17 contracts with Indian health care providers. MNsure shall comply with all future changes
 3.18 in federal law with regard to health coverage for the tribes.

3.19 (j) Health carriers offering coverage through MNsure shall provide a premium
 3.20 advance to qualified individuals eligible for a state tax credit under section 290.0661,
 3.21 equal to the amount of the tax credit calculated under that section. Individuals receiving
 3.22 a premium advance under this paragraph must pay to the health carrier the full amount
 3.23 of the premium advance by April 15 of the year following the coverage year for which
 3.24 the premium advance was provided. The MNsure eligibility system must automatically
 3.25 notify health carriers:

3.26 (1) if an enrollee is eligible for a state tax credit under section 290.0661; and

3.27 (2) the amount of the applicable state tax credit.

3.28 **EFFECTIVE DATE.** This section is effective for taxable years beginning after
 3.29 December 31, 2015.

3.30 **Sec. 2. [290.0661] STATE TAX CREDIT FOR MNSURE PREMIUM PAYMENTS.**

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

3.33 (b) "MNsure" means the insurance exchange established under chapter 62V.

3.34 (c) "Federal poverty guidelines" means the federal poverty guidelines published by
 3.35 the United States Department of Health and Human Services that apply to calculate the

4.1 individual's premium support credit under section 36B of the Internal Revenue Code
4.2 for the taxable year.

4.3 (d) "Qualified individual" means a resident individual applying for, or enrolled in,
4.4 qualified health plan coverage through MNsure with:

4.5 (1) an income greater than 133 percent but not exceeding 200 percent of the federal
4.6 poverty guidelines; or

4.7 (2) an income equal to or less than 133 percent of the federal poverty guidelines, if
4.8 the applicant or enrollee would have been eligible for MinnesotaCare coverage under the
4.9 eligibility criteria specified in Minnesota Statutes 2014, chapter 256L.

4.10 Subd. 2. **Credit allowed; payment to health carrier.** (a) A qualified individual is
4.11 allowed a credit against the tax due under this chapter equal to the amount determined
4.12 under subdivision 3.

4.13 (b) For a part-year resident, the credit must be allocated based on the percentage
4.14 calculated under section 290.06, subdivision 2c, paragraph (e).

4.15 (c) A qualified individual receiving a premium advance under section 62V.05,
4.16 subdivision 5, paragraph (j), must pay to the health carrier the full amount of the premium
4.17 advance by April 15 of the year following the coverage year for which the premium
4.18 advance was provided.

4.19 Subd. 3. **Calculation of credit amount.** The commissioner, in consultation with the
4.20 commissioner of human services and the MNsure board, shall provide qualified individuals
4.21 with tax credits that reduce the cost of MNsure household premiums for qualified health
4.22 plans by specified dollar amounts. The dollar amount of the tax credit must equal the base
4.23 premium reduction amount, adjusted for household size. The commissioner shall establish
4.24 separate base premium reduction amounts, based on a sliding scale, for:

4.25 (1) households with incomes not exceeding 150 percent of the federal poverty
4.26 guidelines; and

4.27 (2) households with incomes greater than 150 percent but not exceeding 200 percent
4.28 of the federal poverty guidelines.

4.29 The commissioner, in developing the tax credit methodology and the base premium
4.30 reduction amounts, shall ensure that aggregate tax credits provided under this section do
4.31 not exceed \$..... per taxable year.

4.32 Subd. 4. **Credit refundable; appropriation.** (a) If the credit allowed under this
4.33 section exceeds the individual's liability under this chapter, the commissioner shall refund
4.34 the excess to the taxpayer.

4.35 (b) An amount sufficient to pay the credits required by this section is appropriated
4.36 from the general fund to the commissioner.

5.1 Subd. 5. **Payment in advance.** The commissioner of human services shall seek
 5.2 all federal approvals and waivers necessary to pay the tax credit established under this
 5.3 section on a monthly basis, in advance, to the health carrier providing qualified health
 5.4 plan coverage to the qualified individual without affecting the amount of the qualified
 5.5 individual's federal premium support credit. If the necessary federal approvals and
 5.6 waivers are obtained, the commissioner of human services shall submit to the legislature
 5.7 any legislative changes necessary to implement advanced payment of tax credits, and
 5.8 the MNsure board shall require health carriers to reduce premiums charged to qualified
 5.9 individuals by the amount of the applicable tax credit.

5.10 **EFFECTIVE DATE.** This section is effective for taxable years beginning after
 5.11 December 31, 2015.

5.12 **ARTICLE 2**

5.13 **MINNESOTACARE**

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

5.15 Subdivision 1. **Wrongfully obtaining assistance.** A person who commits any of
 5.16 the following acts or omissions with intent to defeat the purposes of sections 145.891
 5.17 to 145.897, the MFIP program formerly codified in sections 256.031 to 256.0361, the
 5.18 AFDC program formerly codified in sections 256.72 to 256.871, chapters 256B, 256D,
 5.19 256J, 256K, or 256L, and child care assistance programs, is guilty of theft and shall be
 5.20 sentenced under section 609.52, subdivision 3, clauses (1) to (5):

5.21 (1) obtains or attempts to obtain, or aids or abets any person to obtain by means of
 5.22 a willfully false statement or representation, by intentional concealment of any material
 5.23 fact, or by impersonation or other fraudulent device, assistance or the continued receipt of
 5.24 assistance, to include child care assistance or vouchers produced according to sections
 5.25 145.891 to 145.897 and ~~MinnesotaCare services according to sections~~ premium assistance
 5.26 under section 256.9365, 256.94, and 256L.01 to 256L.15, to which the person is not
 5.27 entitled or assistance greater than that to which the person is entitled;

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

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

5.33 The continued receipt of assistance to which the person is not entitled or greater
 5.34 than that to which the person is entitled as a result of any of the acts, failure to act, or

6.1 concealment described in this subdivision shall be deemed to be continuing offenses from
6.2 the date that the first act or failure to act occurred.

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

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

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

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

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

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

6.26 (d) Adults without children. This proposal includes requesting federal authority to
6.27 impose a limit on assets for adults without children in medical assistance, as defined in
6.28 section 256B.055, subdivision 15, who have a household income equal to or less than
6.29 75 percent of the federal poverty limit, ~~and to impose a 180-day durational residency~~
6.30 ~~requirement in MinnesotaCare, consistent with section 256L.09, subdivision 4, for adults~~
6.31 ~~without children, regardless of income.~~

6.32 (e) Empower and encourage work, housing, and independence. This project provides
6.33 services and supports for individuals who have an identified health or disabling condition
6.34 but are not yet certified as disabled, in order to delay or prevent permanent disability,

7.1 reduce the need for intensive health care and long-term care services and supports, and to
7.2 help maintain or obtain employment or assist in return to work. Benefits may include:

- 7.3 (1) coordination with health care homes or health care coordinators;
- 7.4 (2) assessment for wellness, housing needs, employment, planning, and goal setting;
- 7.5 (3) training services;
- 7.6 (4) job placement services;
- 7.7 (5) career counseling;
- 7.8 (6) benefit counseling;
- 7.9 (7) worker supports and coaching;
- 7.10 (8) assessment of workplace accommodations;
- 7.11 (9) transitional housing services; and
- 7.12 (10) assistance in maintaining housing.

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

- 7.17 (1) provide people less expensive alternatives to medical assistance services;
- 7.18 (2) offer more flexible and updated community support services under the Medicaid
7.19 state plan;
- 7.20 (3) provide an individual budget and increased opportunity for self-direction;
- 7.21 (4) strengthen family and caregiver support services;
- 7.22 (5) allow persons to pool resources or save funds beyond a fiscal year to cover
7.23 unexpected needs or foster development of needed services;
- 7.24 (6) use of home and community-based waiver programs for people whose needs
7.25 cannot be met with the expanded Medicaid state plan community support service options;
- 7.26 (7) target access to residential care for those with higher needs;
- 7.27 (8) develop capacity within the community for crisis intervention and prevention;
- 7.28 (9) redesign case management;
- 7.29 (10) offer life planning services for families to plan for the future of their child
7.30 with a disability;
- 7.31 (11) enhance self-advocacy and life planning for people with disabilities;
- 7.32 (12) improve information and assistance to inform long-term care decisions; and
- 7.33 (13) increase quality assurance, performance measurement, and outcome-based
7.34 reimbursement.

7.35 This project may include different levels of long-term supports that allow seniors to
7.36 remain in their homes and communities, and expand care transitions from acute care to

8.1 community care to prevent hospitalizations and nursing home placement. The levels
8.2 of support for seniors may range from basic community services for those with lower
8.3 needs, access to residential services if a person has higher needs, and targets access to
8.4 nursing home care to those with rehabilitation or high medical needs. This may involve
8.5 the establishment of medical need thresholds to accommodate the level of support
8.6 needed; provision of a long-term care consultation to persons seeking residential services,
8.7 regardless of payer source; adjustment of incentives to providers and care coordination
8.8 organizations to achieve desired outcomes; and a required coordination with medical
8.9 assistance basic care benefit and Medicare/Medigap benefit. This proposal will improve
8.10 access to housing and improve capacity to maintain individuals in their existing home;
8.11 adjust screening and assessment tools, as needed; improve transition and relocation
8.12 efforts; seek federal financial participation for alternative care and essential community
8.13 supports; and provide Medigap coverage for people having lower needs.

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

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

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

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

8.24 (4) reduce administrative complexity;

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

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

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

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

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

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

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

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

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

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

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

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

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

9.30 Sec. 3. Minnesota Statutes 2014, section 270A.03, subdivision 5, is amended to read:

9.31 Subd. 5. **Debt.** (a) "Debt" means a legal obligation of a natural person to pay a fixed
 9.32 and certain amount of money, which equals or exceeds \$25 and which is due and payable
 9.33 to a claimant agency. The term includes criminal fines imposed under section 609.10 or
 9.34 609.125, fines imposed for petty misdemeanors as defined in section 609.02, subdivision

10.1 4a, and restitution. A debt may arise under a contractual or statutory obligation, a court
10.2 order, or other legal obligation, but need not have been reduced to judgment.

10.3 A debt includes any legal obligation of a current recipient of assistance which is
10.4 based on overpayment of an assistance grant where that payment is based on a client
10.5 waiver or an administrative or judicial finding of an intentional program violation;
10.6 or where the debt is owed to a program wherein the debtor is not a client at the time
10.7 notification is provided to initiate recovery under this chapter and the debtor is not a
10.8 current recipient of food support, transitional child care, or transitional medical assistance.

10.9 (b) A debt does not include any legal obligation to pay a claimant agency for medical
10.10 care, including hospitalization if the income of the debtor at the time when the medical
10.11 care was rendered does not exceed the following amount:

10.12 (1) for an unmarried debtor, an income of \$8,800 or less;

10.13 (2) for a debtor with one dependent, an income of \$11,270 or less;

10.14 (3) for a debtor with two dependents, an income of \$13,330 or less;

10.15 (4) for a debtor with three dependents, an income of \$15,120 or less;

10.16 (5) for a debtor with four dependents, an income of \$15,950 or less; and

10.17 (6) for a debtor with five or more dependents, an income of \$16,630 or less.

10.18 (c) The commissioner shall adjust the income amounts in paragraph (b) by the
10.19 percentage determined pursuant to the provisions of section 1(f) of the Internal Revenue
10.20 Code, except that in section 1(f)(3)(B) the word "1999" shall be substituted for the word
10.21 "1992." For 2001, the commissioner shall then determine the percent change from the 12
10.22 months ending on August 31, 1999, to the 12 months ending on August 31, 2000, and in
10.23 each subsequent year, from the 12 months ending on August 31, 1999, to the 12 months
10.24 ending on August 31 of the year preceding the taxable year. The determination of the
10.25 commissioner pursuant to this subdivision shall not be considered a "rule" and shall not
10.26 be subject to the Administrative Procedure Act contained in chapter 14. The income
10.27 amount as adjusted must be rounded to the nearest \$10 amount. If the amount ends in
10.28 \$5, the amount is rounded up to the nearest \$10 amount.

10.29 (d) Debt also includes an agreement to pay a MinnesotaCare premium, regardless
10.30 of the dollar amount of the premium authorized under Minnesota Statutes 2014, section
10.31 256L.15, subdivision 1a.

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

10.33 Sec. 4. Minnesota Statutes 2014, section 270B.14, subdivision 1, is amended to read:

10.34 Subdivision 1. **Disclosure to commissioner of human services.** (a) On the request
10.35 of the commissioner of human services, the commissioner shall disclose return information

11.1 regarding taxes imposed by chapter 290, and claims for refunds under chapter 290A, to
11.2 the extent provided in paragraph (b) and for the purposes set forth in paragraph (c).

11.3 (b) Data that may be disclosed are limited to data relating to the identity,
11.4 whereabouts, employment, income, and property of a person owing or alleged to be owing
11.5 an obligation of child support.

11.6 (c) The commissioner of human services may request data only for the purposes of
11.7 carrying out the child support enforcement program and to assist in the location of parents
11.8 who have, or appear to have, deserted their children. Data received may be used only
11.9 as set forth in section 256.978.

11.10 (d) The commissioner shall provide the records and information necessary to
11.11 administer the supplemental housing allowance to the commissioner of human services.

11.12 (e) At the request of the commissioner of human services, the commissioner of
11.13 revenue shall electronically match the Social Security numbers and names of participants
11.14 in the telephone assistance plan operated under sections 237.69 to 237.71, with those of
11.15 property tax refund filers, and determine whether each participant's household income is
11.16 within the eligibility standards for the telephone assistance plan.

11.17 (f) The commissioner may provide records and information collected under sections
11.18 295.50 to 295.59 to the commissioner of human services for purposes of the Medicaid
11.19 Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law
11.20 102-234. Upon the written agreement by the United States Department of Health and
11.21 Human Services to maintain the confidentiality of the data, the commissioner may provide
11.22 records and information collected under sections 295.50 to 295.59 to the Centers for
11.23 Medicare and Medicaid Services section of the United States Department of Health and
11.24 Human Services for purposes of meeting federal reporting requirements.

11.25 (g) The commissioner may provide records and information to the commissioner of
11.26 human services as necessary to administer the early refund of refundable tax credits.

11.27 ~~(h) The commissioner may disclose information to the commissioner of human
11.28 services necessary to verify income for eligibility and premium payment under the
11.29 MinnesotaCare program, under section 256L.05, subdivision 2.~~

11.30 ~~(h)~~ (h) The commissioner may disclose information to the commissioner of human
11.31 services necessary to verify whether applicants or recipients for the Minnesota family
11.32 investment program, general assistance, food support, Minnesota supplemental aid
11.33 program, and child care assistance have claimed refundable tax credits under chapter 290
11.34 and the property tax refund under chapter 290A, and the amounts of the credits.

12.1 (†) (i) The commissioner may disclose information to the commissioner of human
 12.2 services necessary to verify income for purposes of calculating parental contribution
 12.3 amounts under section 252.27, subdivision 2a.

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

12.5 Sec. 5. Laws 2011, First Special Session chapter 9, article 6, section 97, subdivision 6,
 12.6 is amended to read:

12.7 Subd. 6. **MinnesotaCare provider taxes.** Minnesota Statutes 2010, sections
 12.8 13.4967, subdivision 3; 295.50, subdivisions 1, 1a, 2, 2a, 3, 4, 6, 6a, 7, 9b, 9c, 10a, 10b,
 12.9 12b, 13, 14, and 15; 295.51, subdivisions 1 and 1a; 295.52, subdivisions 1, 1a, 2, 3, 4,
 12.10 4a, 5, 6, and 7; 295.53, subdivisions 1, 2, 3, and 4a; 295.54; 295.55; 295.56; 295.57;
 12.11 295.58; 295.581; 295.582; and 295.59, are repealed effective for gross revenues received
 12.12 after December 31, ~~2019~~ 2018.

12.13 Sec. 6. **REVISOR INSTRUCTION.**

12.14 In Minnesota Statutes and Minnesota Rules, the revisor of statutes shall strike
 12.15 references to Minnesota Statutes, chapter 256L, and to statutory sections within that
 12.16 chapter, and shall make all necessary grammatical and conforming changes.

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

12.18 Sec. 7. **REPEALER.**

12.19 Subdivision 1. **MinnesotaCare program.** Minnesota Statutes 2014, sections
 12.20 256L.01, subdivisions 1, 1a, 1b, 2, 3, 3a, 5, 6, and 7; 256L.02, subdivisions 1, 2, 3, 5, and
 12.21 6; 256L.03, subdivisions 1, 1a, 1b, 2, 3, 3a, 3b, 4, 4a, 5, and 6; 256L.04, subdivisions 1,
 12.22 1a, 1c, 2, 2a, 7, 7a, 7b, 8, 10, 12, 13, and 14; 256L.05, subdivisions 1, 1a, 1b, 1c, 2, 3, 3a,
 12.23 3c, 4, 5, and 6; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3, and 4; 256L.09,
 12.24 subdivisions 1, 2, 4, 5, 6, and 7; 256L.10; 256L.11, subdivisions 1, 2, 2a, 3, 4, and 7;
 12.25 256L.12; 256L.121; 256L.15, subdivisions 1, 1a, 1b, and 2; 256L.18; 256L.22; 256L.24;
 12.26 256L.26; and 256L.28, are repealed.

12.27 Subd. 2. **Conforming repealers.** Minnesota Statutes 2014, sections 13.461,
 12.28 subdivision 26; 16A.724, subdivision 3; and 62A.046, subdivision 5, are repealed.

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

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13.461 HUMAN SERVICES DATA CODED ELSEWHERE.

Subd. 26. **MinnesotaCare.** Data sharing with other government agencies that is needed to verify income for eligibility and premium payment is governed by section 256L.05.

16A.724 HEALTH CARE ACCESS FUND.

Subd. 3. **MinnesotaCare federal receipts.** All federal funding received by Minnesota for implementation and administration of MinnesotaCare as a basic health program, as authorized in section 1331 of the Affordable Care Act, Public Law 111-148, as amended by Public Law 111-152, is appropriated to the commissioner of human services to be used only for the MinnesotaCare program under chapter 256L. Federal funding that is received for implementing and administering MinnesotaCare as a basic health program shall be used only for that program to purchase health care coverage for enrollees and reduce enrollee premiums and cost-sharing or provide additional enrollee benefits.

62A.046 COORDINATION OF BENEFITS.

Subd. 5. **Payment recovery.** The commissioner of human services shall recover payments made by the MinnesotaCare program from the responsible insurer, for services provided by the MinnesotaCare program and covered by the policy or plan of health insurance.

256L.01 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of this chapter, the following terms shall have the meanings given them.

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.

Subd. 1b. **Affordable Care Act.** "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance or regulations issued under, these acts.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 3. **Eligible providers.** "Eligible providers" means those health care providers who provide covered health services to medical assistance recipients under rules established by the commissioner for that program.

Subd. 3a. **Family.** (a) "Family" has the meaning given for family and family size as defined in Code of Federal Regulations, title 26, section 1.36B-1.

(b) The term includes children who are temporarily absent from the household in settings such as schools, camps, or parenting time with noncustodial parents.

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.

Subd. 6. **MNsure.** "MNsure" means the state health benefit exchange as defined in section 62V.02.

Subd. 7. **Participating entity.** "Participating entity" means a health carrier as defined in section 62A.01, subdivision 2; a county-based purchasing plan established under section 256B.692; an accountable care organization or other entity operating a health care delivery systems demonstration project authorized under section 256B.0755; an entity operating a county integrated health care delivery network pilot project authorized under section 256B.0756; or a network of health care providers established to offer services under MinnesotaCare.

256L.02 PROGRAM ADMINISTRATION.

Subdivision 1. **Purpose.** The MinnesotaCare program is established to promote access to appropriate health care services to assure healthy children and adults.

Subd. 2. **Commissioner's duties.** (a) The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide covered health services for eligible persons. Payment for these services shall be made to all participating entities under contract with the commissioner. The commissioner shall adopt rules to administer the MinnesotaCare program. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the Department of Human Services.

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(b) A toll-free telephone number and Web site must be used to provide information about medical programs and to promote access to the covered services.

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

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

Subd. 5. **Federal approval.** (a) The commissioner of human services shall seek federal approval to implement the MinnesotaCare program under this chapter as a basic health program. In any agreement with the Centers for Medicare and Medicaid Services to operate MinnesotaCare as a basic health program, the commissioner shall seek to include procedures to ensure that federal funding is predictable, stable, and sufficient to sustain ongoing operation of MinnesotaCare. These procedures must address issues related to the timing of federal payments, payment reconciliation, enrollee risk adjustment, and minimization of state financial risk. The commissioner shall consult with the commissioner of management and budget, when developing the proposal for establishing MinnesotaCare as a basic health program to be submitted to the Centers for Medicare and Medicaid Services.

(b) The commissioner of human services, in consultation with the commissioner of management and budget, shall work with the Centers for Medicare and Medicaid Services to establish a process for reconciliation and adjustment of federal payments that balances state and federal liability over time. The commissioner of human services shall request that the secretary of health and human services hold the state, and enrollees, harmless in the reconciliation process for the first three years, to allow the state to develop a statistically valid methodology for predicting enrollment trends and their net effect on federal payments.

Subd. 6. **Coordination with MNsure.** MinnesotaCare shall be considered a public health care program for purposes of chapter 62V.

256L.03 COVERED HEALTH SERVICES.

Subdivision 1. **Covered health services.** (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of special education services, home care nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, and nursing home or intermediate care facilities services.

(b) No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

(c) Covered health services shall be expanded as provided in this section.

Subd. 1a. **Children; MinnesotaCare health care reform waiver.** Children are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program

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according to chapter 256B, except that abortion services under MinnesotaCare shall be limited as provided under subdivision 1. Children are exempt from the provisions of subdivision 5, regarding co-payments. Children who are lawfully residing in the United States but who are not "qualified noncitizens" under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all services provided under the medical assistance program according to chapter 256B.

Subd. 1b. **Pregnant women; eligibility for full medical assistance services.** A pregnant woman enrolled in MinnesotaCare is eligible for coverage of all services provided under the medical assistance program according to chapter 256B retroactive to the date of conception. Co-payments totaling \$30 or more, paid after the date of conception, shall be refunded.

Subd. 2. **Alcohol and drug dependency.** Beginning July 1, 1993, covered health services shall include individual outpatient treatment of alcohol or drug dependency by a qualified health professional or outpatient program.

Persons who may need chemical dependency services under the provisions of this chapter shall be assessed by a local agency as defined under section 254B.01, and under the assessment provisions of section 254A.03, subdivision 3. A local agency or managed care plan under contract with the Department of Human Services must place a person in need of chemical dependency services as provided in Minnesota Rules, parts 9530.6600 to 9530.6660. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for consolidated chemical dependency treatment fund services provided under the provisions of chapter 254B shall receive chemical dependency treatment services under the provisions of chapter 254B only if:

- (1) they have exhausted the chemical dependency benefits offered under this chapter; or
- (2) an assessment indicates that they need a level of care not provided under the provisions of this chapter.

Recipients of covered health services under the children's health plan, as provided in Minnesota Statutes 1990, section 256.936, and as amended by Laws 1991, chapter 292, article 4, section 17, and recipients of covered health services enrolled in the children's health plan or the MinnesotaCare program after October 1, 1992, pursuant to Laws 1992, chapter 549, article 4, sections 5 and 17, are eligible to receive alcohol and drug dependency benefits under this subdivision.

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown.

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

- (1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and
- (2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

Subd. 3a. **Interpreter services.** Covered services include sign and spoken language interpreter services that assist an enrollee in obtaining covered health care services.

Subd. 3b. **Chiropractic services.** MinnesotaCare covers the following chiropractic services: medically necessary exams, manual manipulation of the spine, and x-rays.

Subd. 4. **Coordination with medical assistance.** The commissioner shall coordinate the provision of hospital inpatient services under the MinnesotaCare program with enrollee eligibility under the medical assistance spenddown.

Subd. 4a. **Loss ratio.** Health coverage provided through the MinnesotaCare program must have a medical loss ratio of at least 85 percent, as defined using the loss ratio methodology described in section 1001 of the Affordable Care Act.

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;

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(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 the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54.

(b) Paragraph (a) does not apply to children under the age of 21.

(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.

Subd. 6. **Lien.** When the state agency provides, pays for, or becomes liable for covered health services, the agency shall have a lien for the cost of the covered health services upon any and all causes of action accruing to the enrollee, or to the enrollee's legal representatives, as a result of the occurrence that necessitated the payment for the covered health services. All liens under this section shall be subject to the provisions of section 256.015. For purposes of this subdivision, "state agency" includes participating entities, under contract with the commissioner according to section 256L.121.

256L.04 ELIGIBLE PERSONS.

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 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 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.

Subd. 1a. **Social Security number required.** (a) Individuals and families applying for MinnesotaCare coverage must provide a Social Security number.

(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.

Subd. 1c. **General requirements.** To be eligible for coverage under MinnesotaCare, a person must meet the eligibility requirements of this section. A person eligible for MinnesotaCare shall not be considered a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered through MNsure under chapter 62V.

Subd. 2. **Third-party liability, paternity, and other medical support.** (a) To be eligible for MinnesotaCare, individuals and families must 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.

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Subd. 2a. **Applications for other benefits.** To be eligible for MinnesotaCare, individuals and families must take all necessary steps to obtain other benefits as described in Code of Federal Regulations, title 42, section 435.608. Applicants and enrollees must apply for other benefits within 30 days of notification.

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 percent of the federal poverty guidelines for the applicable family size.

Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under this section may not enroll in the MinnesotaCare program.

Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income limits under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services except that the income standards shall not go below those in effect on July 1, 2009.

Subd. 8. **Applicants potentially eligible for medical assistance.** (a) Individuals who receive Supplemental Security Income or retirement, survivors, or disability benefits due to a disability, or other disability-based pension, who qualify under subdivision 7, but who are potentially eligible for medical assistance without a spenddown shall be allowed to enroll in MinnesotaCare, so long as the applicant meets all other conditions of eligibility. The commissioner shall identify and refer the applications of such individuals to their county social service agency. The county and the commissioner shall cooperate to ensure that the individuals obtain medical assistance coverage for any months for which they are eligible.

(b) The enrollee must cooperate with the county social service agency in determining medical assistance eligibility. Enrollees who do not cooperate with medical assistance shall be disenrolled from the plan within one calendar month. Persons disenrolled for nonapplication for medical assistance may not reenroll until they have obtained a medical assistance eligibility determination. Persons disenrolled for noncooperation with medical assistance may not reenroll until they have cooperated with the county agency and have obtained a medical assistance eligibility determination.

(c) Counties that choose to become MinnesotaCare enrollment sites shall consider MinnesotaCare applications to also be applications for medical assistance.

(d) The commissioner shall redetermine provider payments made under MinnesotaCare to the appropriate medical assistance payments for those enrollees who subsequently become eligible for medical assistance.

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States and lawfully present noncitizens as defined in Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens are ineligible for MinnesotaCare. For purposes of this subdivision, an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who are 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) Notwithstanding subdivisions 1 and 7, eligible persons include families and individuals who are lawfully present and ineligible for medical assistance by reason of immigration status and who have incomes equal to or less than 200 percent of federal poverty guidelines.

Subd. 12. **Persons in detention.** An applicant or enrollee residing in a correctional or detention facility is not eligible for MinnesotaCare, unless the applicant or enrollee is awaiting disposition of charges.

Subd. 13. **Families with relative caretakers, foster parents, or legal guardians.** Beginning January 1, 1999, in families that include a relative caretaker as defined in the medical assistance program, foster parent, or legal guardian, the relative caretaker, foster parent, or legal guardian may apply as a family or may apply separately for the children. If the caretaker applies separately for the children, only the children's income is counted and the provisions of subdivision 1, paragraph (b), do not apply. If the relative caretaker, foster parent, or legal guardian applies with the children, their income is included in the gross family income for determining eligibility and premium amount.

Subd. 14. **Coordination with medical assistance.** (a) Individuals eligible for medical assistance under chapter 256B are not eligible for MinnesotaCare under this section.

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(b) The commissioner shall coordinate eligibility and coverage to ensure that individuals transitioning between medical assistance and MinnesotaCare have seamless eligibility and access to health care services.

256L.05 APPLICATION PROCEDURES.

Subdivision 1. **Application assistance and information availability.** (a) Applicants may submit applications online, in person, by mail, or by phone in accordance with the Affordable Care Act, and by any other means by which medical assistance applications may be submitted. Applicants may submit applications through MNsure or through the MinnesotaCare program. Applications and application assistance must be made available at provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches, community health offices, Women, Infants and Children (WIC) program sites, Head Start program sites, public housing councils, crisis nurseries, child care centers, early childhood education and preschool program sites, legal aid offices, and libraries, and at any other locations at which medical assistance applications must be made available. These sites may accept applications and forward the forms to the commissioner or local county human services agencies that choose to participate as an enrollment site. Otherwise, applicants may apply directly to the commissioner or to participating local county human services agencies.

(b) Application assistance must be available for applicants choosing to file an online application through MNsure.

Subd. 1a. **Person authorized to apply on applicant's behalf.** Beginning January 1, 1999, a family member who is age 18 or over or who is an authorized representative, as defined in the medical assistance program, may apply on an applicant's behalf.

Subd. 1b. **MinnesotaCare enrollment by county agencies.** Beginning September 1, 2006, county agencies shall enroll single adults and households with no children formerly enrolled in general assistance medical care in MinnesotaCare according to Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3. County agencies shall perform all duties necessary to administer the MinnesotaCare program ongoing for these enrollees, including the redetermination of MinnesotaCare eligibility at renewal.

Subd. 1c. **Open enrollment and streamlined application and enrollment process.**

Subd. 2. **Commissioner's duties.** The commissioner or county agency shall use electronic verification through MNsure as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual may be required to submit additional verification to the extent permitted under the Affordable Care Act. In addition, the commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the Department of Revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the MinnesotaCare program.

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. The effective date of coverage for new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's modified adjusted gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

(d) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, subdivision 1, paragraph (c), is the first day of the month following the month in which verification of American Indian status is received or eligibility is approved, whichever is later.

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

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(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) For children enrolled in MinnesotaCare, the first period of renewal begins the month the enrollee turns 21 years of age.

Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective date of coverage shall be the first day of the month following termination from medical assistance for families and individuals who are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance. The applicant must provide all required verifications within 30 days of the written request for verification. For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing. This subdivision does not apply, and shall not be implemented by the commissioner, once eligibility determination for MinnesotaCare is conducted by the MNsure eligibility determination system.

Subd. 4. **Application processing.** The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than 30 days from the date that the application is received by the Department of Human Services. Beginning January 1, 2000, this requirement also applies to local county human services agencies that determine eligibility for MinnesotaCare.

Subd. 5. **Availability of private insurance.** The commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage and the possibility of disenrollment under section 256L.07, subdivision 1, to all: (1) families enrolled in the MinnesotaCare program whose gross family income is equal to or more than 225 percent of the federal poverty guidelines; and (2) single adults and households without children enrolled in the MinnesotaCare program whose gross family income is equal to or more than 165 percent of the federal poverty guidelines. This information must be provided upon initial enrollment and annually thereafter. The commissioner shall also include information regarding the availability of private health insurance coverage in the notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1.

Subd. 6. **Referral of veterans.** The commissioner shall ensure that all applicants for MinnesotaCare who identify themselves as veterans are referred to a county veterans service officer for assistance in applying to the United States Department of Veterans Affairs for any veterans benefits for which they may be eligible.

256L.06 PREMIUM ADMINISTRATION.

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 for which the premium was due. Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment.

256L.07 ELIGIBILITY FOR MINNESOTACARE.

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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, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

Subd. 2. **Must not have access to employer-subsidized minimum essential coverage.**

(a) To be eligible, a family or individual must not have access to subsidized health coverage that is affordable and provides minimum value as defined in Code of Federal Regulations, title 26, section 1.36B-2.

(b) This subdivision does not apply to a family or individual who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit.

Subd. 3. **Other health coverage.** (a) To be eligible, a family or individual must not have minimum essential health coverage, as defined by section 5000A of the Internal Revenue Code.

(b) For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to have minimum essential health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

Subd. 4. **Families with children in need of chemical dependency treatment.** Premiums for families with children when a parent has been determined to be in need of chemical dependency treatment pursuant to an assessment conducted by the county under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, who are eligible for MinnesotaCare under section 256L.04, subdivision 1, may be paid by the county of residence of the person in need of treatment for one year from the date the family is determined to be eligible or if the family is currently enrolled in MinnesotaCare from the date the person is determined to be in need of chemical dependency treatment. Upon renewal, the family is responsible for any premiums owed under section 256L.15. If the family is not currently enrolled in MinnesotaCare, the local county human services agency shall determine whether the family appears to meet the eligibility requirements and shall assist the family in applying for the MinnesotaCare program.

256L.09 RESIDENCY.

Subdivision 1. **Findings and purpose.** The legislature finds that the enactment of a comprehensive health plan for uninsured Minnesotans creates a risk that persons needing medical care will migrate to the state for the primary purpose of obtaining medical care subsidized by the state. The risk of migration undermines the state's ability to provide to legitimate state residents a valuable and necessary health care program which is an important component of the state's comprehensive cost containment and health care system reform plan. Intent-based residency requirements, which are expressly authorized under decisions of the United States Supreme Court, are an unenforceable and ineffective method of denying benefits to those persons the Supreme Court has stated may legitimately be denied eligibility for state programs. If the state is unable to limit eligibility to legitimate permanent residents of the state, the state faces a significant risk that it will be forced to reduce the eligibility and benefits it would otherwise provide to Minnesotans. The legislature finds that a durational residence requirement is a legitimate, objective, enforceable standard for determining whether a person is a permanent resident of the state. The legislature also finds low-income persons who have not lived in the state for the required time period will have access to necessary health care services through the general assistance medical care program, the medical assistance program, and public and private charity care programs.

Subd. 2. **Residency requirement.** To be eligible for health coverage under the MinnesotaCare program, individuals and families with children must meet the residency requirements as provided by Code of Federal Regulations, title 42, section 435.403.

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

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

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

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

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

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

Subd. 5. **Persons excluded as permanent residents.** An individual or family that moved to Minnesota primarily to obtain medical treatment or health coverage for a preexisting condition is not a permanent resident.

Subd. 6. **12-month preexisting exclusion.** If the 180-day requirement in subdivision 4, paragraph (b), clause (2), is determined by a court to be unconstitutional, the commissioner of human services shall impose a 12-month preexisting condition exclusion on coverage for persons who have been domiciled in the state for less than 180 days.

Subd. 7. **Effect of a court determination.** If any paragraph, sentence, clause, or phrase of this section is for any reason determined by a court to be unconstitutional, the decision shall not affect the validity of the remaining portions of the section. The legislature declares that it would have passed each paragraph, sentence, clause, and phrase in this section, irrespective of the fact that any one or more paragraphs, sentences, clauses, or phrases is declared unconstitutional.

256L.10 APPEALS.

If the commissioner suspends, reduces, or terminates eligibility for the MinnesotaCare program, or services provided under the MinnesotaCare program, the commissioner must provide notification according to the laws and rules governing the medical assistance program. A MinnesotaCare program applicant or enrollee aggrieved by a determination of the commissioner has the right to appeal the determination according to section 256.045.

256L.11 PROVIDER PAYMENT.

Subdivision 1. **Medical assistance rate to be used.** Payment to providers under this chapter shall be at the same rates and conditions established for medical assistance, except as provided in this section.

Subd. 2. **Payment of certain providers.** Services provided by federally qualified health centers, rural health clinics, and facilities of the Indian health service shall be paid for according to the same rates and conditions applicable to the same service provided by providers that are not federally qualified health centers, rural health clinics, or facilities of the Indian health service.

Subd. 2a. **Payment rates; services for families and children under the MinnesotaCare health care reform waiver.** Subdivision 2 shall not apply to services provided to families with children who are eligible according to section 256L.04, subdivision 1, paragraph (a).

Subd. 3. **Inpatient hospital services.** Inpatient hospital services provided under section 256L.03, subdivision 3, shall be at the medical assistance rate.

Subd. 4. **Definition of medical assistance rate for inpatient hospital services.** The "medical assistance rate," as used in this section to apply to rates for providing inpatient hospital services, means the rates established under sections 256.9685 to 256.9695 for providing inpatient hospital services to medical assistance recipients who receive Minnesota family investment program assistance.

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2007, through August 31, 2011, 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 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.

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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.

256L.12 MANAGED CARE.

Subdivision 1. **Selection of vendors.** In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall, where possible, contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for managed care plans and managed care-like entities as defined by the final regulation implementing section 1331 of the Affordable Care Act regarding basic health plans, which may include: prepaid capitation programs, competitive bidding programs, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided.

Subd. 2. **Geographic area.** The commissioner shall designate the geographic areas in which eligible individuals must receive services through managed care plans.

Subd. 3. **Limitation of choice.** Persons enrolled in the MinnesotaCare program who reside in the designated geographic areas must enroll in a managed care plan to receive their health care services. Enrollees must receive their health care services from health care providers who are part of the managed care plan provider network, unless authorized by the managed care plan, in cases of medical emergency, or when otherwise required by law or by contract.

If only one managed care option is available in a geographic area, the managed care plan may require that enrollees designate a primary care provider from which to receive their health care. Enrollees will be permitted to change their designated primary care provider upon request to the managed care plan. Requests to change primary care providers may be limited to once annually. If more than one managed care plan is offered in a geographic area, enrollees will be enrolled in a managed care plan for up to one year from the date of enrollment, but shall have the right to change to another managed care plan once within the first year of initial enrollment. Enrollees may also change to another managed care plan during an annual 30-day open enrollment period. Enrollees shall be notified of the opportunity to change to another managed care plan before the start of each annual open enrollment period.

Enrollees may change managed care plans or primary care providers at other than the above designated times for cause as determined through an appeal pursuant to section 256.045.

Subd. 4. **Exemptions to limitations on choice.** All contracts between the Department of Human Services and prepaid health plans to serve medical assistance, general assistance medical care, and MinnesotaCare recipients must comply with the requirements of United States Code, title 42, section 1396a (a)(23)(B), notwithstanding any waivers authorized by the United States Department of Health and Human Services pursuant to United States Code, title 42, section 1315.

Subd. 5. **Eligibility for other state programs.** MinnesotaCare enrollees who become eligible for medical assistance will remain in the same managed care plan if the managed care plan has a contract for that population. MinnesotaCare enrollees who were formerly eligible for general assistance medical care pursuant to section 256D.03, subdivision 3, within six months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant to section 256D.03, subdivision 4, paragraph (c), must remain in the same managed care plan if the managed care plan has a contract for that population. Managed care plans must participate in the MinnesotaCare program under a contract with the Department of Human Services in service areas where they participate in the medical assistance program.

Subd. 6. **Co-payments and benefit limits.** Enrollees are responsible for all co-payments in section 256L.03, subdivision 5, and shall pay co-payments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit.

Subd. 7. **Managed care plan vendor requirements.** The following requirements apply to all counties or vendors who contract with the Department of Human Services to serve MinnesotaCare recipients. Managed care plan contractors:

(1) shall authorize and arrange for the provision of the full range of services listed in section 256L.03 in order to ensure appropriate health care is delivered to enrollees;

(2) shall accept the prospective, per capita payment or other contractually defined payment from the commissioner in return for the provision and coordination of covered 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;

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(4) shall provide for an enrollee grievance process as required by the commissioner and set forth in the contract with the department;

(5) shall retain all revenue from enrollee co-payments;

(6) shall accept all eligible MinnesotaCare enrollees, without regard to health status or previous utilization of health services;

(7) shall demonstrate capacity to accept financial risk according to requirements specified in the contract with the department. A health maintenance organization licensed under chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required to demonstrate financial risk capacity, beyond that which is required to comply with chapters 62C and 62D; and

(8) shall submit information as required by the commissioner, including data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services.

Subd. 8. Chemical dependency assessments. The managed care plan shall be responsible for assessing the need and placement for chemical dependency services according to criteria set forth in Minnesota Rules, parts 9530.6600 to 9530.6660.

Subd. 9. Rate setting; performance withholds. (a) Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions, when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

(c) For services rendered on or after January 1, 2011, the commissioner shall withhold an additional three percent of managed care plan or county-based purchasing plan payments under this section. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year. The return of the withhold under this paragraph is not subject to the requirements of paragraph (b).

(d) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reductions shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous measurement year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of

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the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

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

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous calendar year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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

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

(f) Effective for services provided on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospital admissions rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

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

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

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

Subd. 9a. Rate setting; ratable reduction. For services rendered on or after October 1, 2003, the total payment made to managed care plans under the MinnesotaCare program is reduced 1.0 percent. This provision excludes payments for mental health services added as covered benefits after December 31, 2007.

Subd. 9b. Rate setting; ratable reduction. In addition to the reduction in subdivision 9a, the total payment made to managed care plans under the MinnesotaCare program shall be

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reduced for services provided on or after January 1, 2006, to reflect a 6.0 percent reduction in reimbursement for inpatient hospital services.

Subd. 10. **Childhood immunization.** Each managed care plan contracting with the Department of Human Services under this section shall collaborate with the local public health agencies to ensure childhood immunization to all enrolled families with children. As part of this collaboration the plan must provide the families with a recommended immunization schedule.

Subd. 11. **Coverage at Indian health service facilities.** For American Indian enrollees of MinnesotaCare, MinnesotaCare shall cover health care services provided at Indian health service facilities 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 Act, Public Law 93-638, if those services would otherwise be covered under section 256L.03. Payments for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or organization, be made at the rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34, for those MinnesotaCare enrollees eligible for coverage at medical assistance rates. For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in Code of Federal Regulations, title 42, section 36.12.

256L.121 SERVICE DELIVERY.

Subdivision 1. **Competitive process.** The commissioner of human services shall establish a competitive process for entering into contracts with participating entities for the offering of standard health plans through MinnesotaCare. Coverage through standard health plans must be available to enrollees beginning January 1, 2015. Each standard health plan must cover the health services listed in and meet the requirements of section 256L.03. The competitive process must meet the requirements of section 1331 of the Affordable Care Act and be designed to ensure enrollee access to high-quality health care coverage options. The commissioner, to the extent feasible, shall seek to ensure that enrollees have a choice of coverage from more than one participating entity within a geographic area. In counties that were part of a county-based purchasing plan on January 1, 2013, the commissioner shall use the medical assistance competitive procurement process under section 256B.69, subdivisions 1 to 32, under which selection of entities is based on criteria related to provider network access, coordination of health care with other local services, alignment with local public health goals, and other factors.

Subd. 2. **Other requirements for participating entities.** The commissioner shall require participating entities, as a condition of contract, to document to the commissioner:

(1) the provision of culturally and linguistically appropriate services, including marketing materials, to MinnesotaCare enrollees; and

(2) the inclusion in provider networks of providers designated as essential community providers under section 62Q.19.

Subd. 3. **Coordination with state-administered health programs.** The commissioner shall coordinate the administration of the MinnesotaCare program with medical assistance to maximize efficiency and improve the continuity of care. This includes, but is not limited to:

(1) establishing geographic areas for MinnesotaCare that are consistent with the geographic areas of the medical assistance program, within which participating entities may offer health plans;

(2) requiring, as a condition of participation in MinnesotaCare, participating entities to also participate in the medical assistance program;

(3) complying with sections 256B.69, subdivision 3a; 256B.692, subdivision 1; and 256B.694, when contracting with MinnesotaCare participating entities;

(4) providing MinnesotaCare enrollees, to the extent possible, with the option to remain in the same health plan and provider network, if they later become eligible for medical assistance or coverage through MNsure and if, in the case of becoming eligible for medical assistance, the enrollee's MinnesotaCare health plan is also a medical assistance health plan in the enrollee's county of residence; and

(5) establishing requirements and criteria for selection that ensure that covered health care services will be coordinated with local public health services, social services, long-term care services, mental health services, and other local services affecting enrollees' health, access, and quality of care.

256L.15 PREMIUMS.

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

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(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 status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums.

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

- (1) payment by check;
- (2) payment by credit card;
- (3) payment by recurring automatic checking withdrawal;
- (4) payment by onetime electronic transfer of funds;
- (5) payment by wage withholding with the consent of the employer and the employee; or
- (6) payment by using state tax refund payments.

At application or reapplication, a MinnesotaCare applicant or enrollee may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to collect funds from the applicant's or enrollee's refund for the purposes of meeting all or part of the applicant's or enrollee's MinnesotaCare premium obligation. The applicant or enrollee may authorize the commissioner to apply for the state working family tax credit on behalf of the applicant or enrollee. The setoff due under this subdivision shall not be subject to the \$10 fee under section 270A.07, subdivision 1.

Subd. 1b. **Payments nonrefundable.** Only MinnesotaCare premiums paid for future months of coverage for which a health plan capitation fee has not been paid may be refunded.

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 (c) with the exception that children 20 years of age and younger in families with income at or below 200 percent of the federal poverty guidelines shall pay no premiums.

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

Federal Poverty Guideline		Individual Premium Amount
Greater than or Equal to	Less than	
0%	55%	\$4
55%	80%	\$6
80%	90%	\$8
90%	100%	\$10
100%	110%	\$12
110%	120%	\$15
120%	130%	\$18
130%	140%	\$21
140%	150%	\$25
150%	160%	\$29
160%	170%	\$33
170%	180%	\$38

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180%	190%	\$43
190%		\$50

256L.18 PENALTIES.

Whoever obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, or by the intentional withholding or concealment of a material fact, or by impersonation, or other fraudulent device:

- (1) benefits under the MinnesotaCare program to which the person is not entitled; or
 - (2) benefits under the MinnesotaCare program greater than that to which the person is reasonably entitled;
- shall be considered to have violated section 256.98, and shall be subject to both the criminal and civil penalties provided under that section.

256L.22 DEFINITION; CHILDREN'S HEALTH PROGRAM.

For purposes of sections 256L.22 to 256L.28, "children's health program" means the medical assistance and MinnesotaCare programs to the extent medical assistance and MinnesotaCare provide health coverage to children.

256L.24 HEALTH CARE ELIGIBILITY FOR CHILDREN.

Subdivision 1. **Applicability.** This section applies to children who are enrolled in a children's health program.

Subd. 2. **Application procedure.** The commissioner shall develop an application form for children's health programs for children that is easily understandable and does not exceed four pages in length. The provisions of section 256L.05, subdivision 1, apply.

Subd. 3. **Premiums.** Children enrolled in MinnesotaCare shall pay premiums as provided in section 256L.15.

Subd. 4. **Eligibility renewal.** The commissioner shall require children enrolled in MinnesotaCare to renew eligibility every 12 months.

256L.26 ASSISTANCE TO APPLICANTS.

The commissioner shall assist children in choosing a managed care organization to receive services under a children's health program, by:

- (1) establishing a Web site to provide information about managed care organizations and to allow online enrollment;
- (2) making applications and information on managed care organizations available to applicants and enrollees according to Title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Department of Health and Human Services; and
- (3) making benefit educators available to assist applicants in choosing a managed care organization.

256L.28 FEDERAL APPROVAL.

The commissioner shall seek all federal waivers and approvals necessary to implement sections 256L.22 to 256L.28, including, but not limited to, waivers and approvals necessary to:

- (1) coordinate medical assistance and MinnesotaCare coverage for children; and
- (2) maximize receipt of the federal medical assistance match for covered children, by increasing income standards through the use of more liberal income methodologies as provided under United States Code, title 42, sections 1396a and 1396u-1.