State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH SESSION

HOUSE FILE NO. 1

January 8, 2007
Authored by Thissen; Morrow; Ruud; Fritz; Murphy, E., and others
The bill was read for the first time and referred to the Committee on Health and Human Services
February 13, 2007
Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Governmental Operations, Reform, Technology and Elections
February 26, 2007
Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Finance

A bill for an act

relating to human services; creating a children's health security account; establishing the children's health security program; specifying eligibility criteria, covered services, and administrative procedures; establishing service delivery and payment rates; providing for consumer assistance and quality monitoring; establishing the children's health security program outreach; establishing a task force on children's health care coverage; authorizing rulemaking; requiring reports; appropriating money; amending Minnesota Statutes 2006, section 256B.057, subdivision 8; proposing coding for new law in Minnesota Statutes, chapter 16A; proposing coding for new law as Minnesota Statutes, chapter 256N.

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

Section 1. **[16A.726] CHILDREN'S HEALTH SECURITY ACCOUNT.**

A children's health security account is created in a special revenue fund in the state treasury. The commissioner shall deposit to the credit of the account money made available to the account. Notwithstanding section 11A.20, any investment income attributable to the investment of the children's health security account not currently needed shall be credited to the children's health security account.

Sec. 2. Minnesota Statutes 2006, section 256B.057, subdivision 8, is amended to read:

Subd. 8. **Children under age two.** Medical assistance may be paid for a child under two years of age whose countable family income is above ~~275~~ 300 percent of the federal poverty guidelines for the same size family but less than or equal to ~~280~~ 305 percent of the federal poverty guidelines for the same size family.

EFFECTIVE DATE. This section is effective July 1, 2008, or upon federal approval, whichever is later.

Sec. 3. **[256N.01] CITATION.**

This chapter may be cited as the "Children's Health Security Act."

Sec. 4. **[256N.02] DEFINITIONS.**

Subdivision 1. **Applicability.** The terms used in this chapter have the following meanings unless otherwise provided for by text.

Subd. 2. **Child.** "Child" means an individual under age 21.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 4. **Dependent child.** "Dependent child" means an unmarried child under age 25 who is claimed as a dependent for federal income tax purposes by a parent, grandparent, foster parent, relative caretaker, or legal guardian.

Sec. 5. **[256N.03] ESTABLISHMENT.**

The commissioner shall establish the children's health security program. The commissioner shall begin implementation of the program on July 1, 2008, or upon federal approval, whichever is later. The children's health security program must comply with title XIX of the Social Security Act, and waivers granted under title XIX.

Sec. 6. **[256N.05] ELIGIBILITY.**

Subdivision 1. **General requirements.** Children meeting the eligibility requirements of this section are eligible for the children's health security program.

Subd. 2. **Income limit.** (a) Children in families with gross household incomes equal to or less than 300 percent of the federal poverty guidelines are eligible for the children's health security program. In determining gross income, the commissioner shall use the income methodology applied to children under the MinnesotaCare program.

(b) Effective July 1, 2008, a dependent child is eligible for state-funded benefits under this section.

(c) Effective July 1, 2010, children in families with household incomes in excess of 300 percent of the federal poverty guidelines must be included in the children's health security program. The requirements for eligibility, the form of the benefits, and other terms and conditions of the program must be determined by the legislature after receiving the report of the Legislative Task Force on Children's Health Coverage established under section 19.

Subd. 3. **Residency.** (a) To be eligible for health coverage under the children's health security program, children must be permanent residents of Minnesota. For purposes

of this requirement, 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, or the applicant's parent or guardian as applicable, must demonstrate the requisite intent to live in the state permanently by:

(1) showing that the applicant, or the applicant's parent or guardian as applicable, maintains a residence at a verified address, through the use of evidence of residence described in paragraph (c); and

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

(c) An applicant, or a parent or guardian of an applicant, may verify a residence address by presenting a valid state driver's license, a state identification card, a voter registration card, a rent receipt, a statement by the landlord, an apartment or emergency shelter manager, or a homeowner verifying that the individual is residing at the address, or other form of verification approved by the commissioner.

(d) A child who is temporarily absent from the state does not lose eligibility for the children's health security program. "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.

(e) A child who moved to Minnesota primarily to obtain medical treatment or health coverage for a preexisting condition is not a permanent resident.

Subd. 4. **Enrollment voluntary.** Enrollment in the children's health security program is voluntary. Parents or guardians may retain private sector or Medicare coverage for a child as the sole source of coverage. Parents or guardians who have private sector or Medicare coverage for children may also enroll children in the children's health security program. If private sector or Medicare coverage is available, coverage under the children's health security program is secondary to the private sector or Medicare coverage.

Subd. 5. **Emergency services.** Payment must be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if the care and services are necessary for the treatment of an emergency medical condition, except for organ transplants and related

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

Subd. 6. **Medical assistance standards and procedures.** (a) Unless otherwise specified in this chapter, the commissioner shall use medical assistance procedures and methodology when determining initial eligibility and redetermining eligibility for the children's health security program.

(b) The procedures and income standard specified in section 256B.056, subdivisions 5 and 5c, paragraph (a), apply to children who would be eligible for the children's health security program, except for excess income.

(c) Retroactive coverage for the children's health security program must be provided as specified in section 256B.056, subdivision 7.

Sec. 7. **[256N.07] COVERED SERVICES.**

Covered services under the children's health security program must consist of all covered services under chapter 256B.

Sec. 8. **[256N.09] NO ENROLLEE PREMIUMS OR COST SHARING.**

In order to ensure broad access to coverage, the children's health security program has no enrollee premium or cost-sharing requirements.

Sec. 9. **[256N.11] APPLICATION PROCEDURES; ELIGIBILITY DETERMINATION.**

Subdivision 1. **Application procedure.** The application form for the program must be easily understandable and must not exceed two pages in length. Applications for the program must be made available to provider offices, local human services agencies, school districts, schools, community health offices, and other sites willing to cooperate in program outreach. These sites may accept applications and forward applications to the commissioner. Applications may also be made directly to the commissioner.

Subd. 2. **Eligibility determination.** The commissioner shall determine an applicant's eligibility for the program within 30 days of the date the application is received by the commissioner, according to the procedures set forth in Code of Federal Regulations, title 42, section 435.911.

Subd. 3. **Presumptive eligibility.** Coverage under the program is available during a presumptive eligibility period for children under age 19 whose family income does not exceed the applicable income standard. The presumptive eligibility period begins on the

date on which a health care provider enrolled in the program, or other entity designated by the commissioner, determines, based on preliminary information, that the child's family income does not exceed the applicable income standard. The presumptive eligibility period ends the earlier of the day on which a determination is made of eligibility under this section or the last day of the month following the month presumptive eligibility was determined.

Subd. 4. **Renewal of eligibility.** The commissioner shall require enrollees to renew eligibility every 12 months.

Subd. 5. **Continuous eligibility.** Children under the age of 19 who are eligible under this section shall be continuously eligible until the earlier of the next renewal period, or the time that a child exceeds age 19.

Sec. 10. **[256N.12] COUNTY ROLE.**

Counties may choose to determine eligibility under section 256N.11, provide assistance to applicants under section 256N.17, subdivision 1, and provide ombudsperson services under section 256N.17, subdivision 2. This must not limit the ability of the commissioner to establish reasonable staffing standards that relate to the number of persons served, and that provide a county option to hire part-time staff or pursue multicounty implementation models. If a county chooses not to deliver these services, they must be delivered by the commissioner. If as a result of state assumption of these roles, county staff with expertise and experience in these areas are laid off, they must be given hiring consideration by the commissioner in staffing these functions within the Department of Human Services. State and federal funding to support these services must be the same, whether delivered by the state or by a county or group of counties.

Sec. 11. **[256N.13] SERVICE DELIVERY.**

Subdivision 1. **Contracts for service delivery.** The commissioner, within each county, may contract with managed care organizations, including health maintenance organizations licensed under chapter 62D, community integrated service networks licensed under chapter 62N, accountable provider networks licensed under chapter 62T, and county-based purchasing plans established under section 256B.692, to provide covered health care services to program enrollees under a managed care system, and may contract with health care and social service providers to provide services on a fee-for-service basis. Section 256B.69, subdivision 26, applies to contracts with managed care organizations. In determining the method for service delivery, the commissioner shall consider the cost and quality of health care services; the breadth of services offered, including medical, dental and mental health services; the breadth of choice of medical providers for enrollees; the

ease of access to quality medical care for enrollees; the efficiency and cost-effectiveness of service delivery; and the integration of best medical practice standards into the children's health security program.

Subd. 2. **Managed care organization requirements.** (a) Managed care organizations under contract are responsible for coordinating covered health care services provided to eligible individuals. Managed care organizations under contract:

(1) shall authorize and arrange for the provision of all needed covered health services under chapter 256B, with the exception of services available only under a medical assistance home and community-based waiver, in order to ensure appropriate health care is delivered to enrollees;

(2) shall comply with the requirements of section 256B.69, subdivision 26;

(3) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for enrollees;

(4) may contract with health care and social service providers to provide covered services to enrollees; and

(5) shall institute enrollee grievance procedures according to the method established by the commissioner, utilizing applicable requirements of chapter 62D and Code of Federal Regulations, title 42, section 438, subpart F. Disputes may also be appealed to the commissioner using the procedures in section 256.045.

(b) Upon implementation of the children's health security program, the commissioner shall withhold five percent of managed care organization payments pending completion of performance targets, including lead screening, well child services, immunizations, vision screening, and customer service performance targets. Effective for services rendered on or after January 1, 2010, the commissioner shall increase the withhold by an additional two percent, for a total withhold of seven percent of managed care organization payments and shall add treatment of asthma and screening for mental health as new performance targets. Each performance target must apply uniformly to all managed care organizations, and be qualitative, objective, measurable, and reasonably attainable, except in the case of a performance target based on federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The withhold funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The success of each managed care organization in reaching performance targets must be reported to the legislature annually.

Subd. 3. **Fee-for-service delivery.** Disputes related to services provided under the fee-for-service system may be appealed to the commissioner using the procedures in section 256.045.

Subd. 4. **Contracts for waiver services.** The commissioner, when services are delivered through managed care, may contract with health care and social service providers on a fee-for-service basis to provide program enrollees with covered services available only under a medical assistance home and community-based waiver. The commissioner shall determine eligibility for home and community-based waiver services using the criteria and procedures in chapter 256B. Disputes related to services provided on a fee-for-service basis may be appealed to the commissioner using the procedures in section 256.045.

Subd. 5. **Service delivery for Minnesota disabilities health option recipient.** Individuals who voluntarily enroll in the Minnesota Disability Health Option (MnDHO), established under section 256B.69, subdivision 23, shall continue to receive their home and community-based waiver services through MnDHO.

Subd. 6. **Disabled or blind children.** Children eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team are exempt from enrolling in a managed care organization and shall be provided health benefits on a fee-for-service basis.

Sec. 12. **[256N.15] PAYMENT RATES.**

Subdivision 1. **Establishment.** The commissioner, in consultation with a health care actuary, shall establish the method and amount of payments for services. The commissioner shall annually contract with eligible entities to provide services to program enrollees. The commissioner, in consultation with the Risk Adjustment Association established under section 62Q.03, subdivision 6, shall develop and implement a risk adjustment system for the program.

Subd. 2. **Provider rates.** In establishing the payment amount under subdivision 1, the commissioner shall ensure that fee-for-service payment rates for preventative care services provided on or after July 1, 2008, are at least five percent above the medical assistance rates for preventative services in effect on June 30, 2008, and shall ensure that fee-for-service payment rates for all other services provided on or after July 1, 2008, are at least three percent above the medical assistance rates for those services in effect on June 30, 2008. The commissioner shall adjust managed care capitation rates to reflect these increases, and shall require managed care organizations, as a condition of contract, to pass these increases on to providers under contract.

Subd. 3. **Performance rate bonus.** The commissioner shall establish a care coordination performance target bonus plan for fee-for-service providers and providers under contract with a managed care organization to serve program clients. The plan

shall establish care coordination and preventative care performance targets for providers. The performance targets must be qualitative, objective, and measurable. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Providers shall submit to the commissioner by March 1 of each year information specified by the commissioner that demonstrates the provider has met the performance targets for the prior year. If the commissioner determines the provider has satisfied the performance targets, the commissioner shall pay directly to the provider a care coordination performance bonus equal to one and one-half percent of all payments for services under the children's health security program made to that provider during the prior year. Managed care organizations shall provide to the commissioner, in the form and manner specified by the commissioner, all information necessary to implement the performance target bonus plan for providers under contract.

Sec. 13. **[256N.17] CONSUMER ASSISTANCE.**

Subdivision 1. **Assistance to applicants.** The commissioner shall assist applicants in choosing a managed care organization or fee-for-service provider by:

(1) establishing a Web site to provide information about managed care organizations and fee-for-service providers and to allow online enrollment;

(2) make information on managed care organizations and fee-for-service providers available at the sites specified in section 256N.11, subdivision 1;

(3) make applications and information on managed care organizations and fee-for-service providers 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

(4) make benefit educators available to assist applicants in choosing a managed care organization or fee-for-service provider.

Subd. 2. **Ombudsperson.** The commissioner shall designate an ombudsperson to advocate for children enrolled in the children's health security program. The ombudsperson shall assist enrollees in understanding and making use of complaint and appeal procedures and ensure that necessary medical services are provided to enrollees. At the time of enrollment, the commissioner shall inform enrollees about the ombudsperson program, the right to a resolution of the enrollee's complaint by the managed care organization if the enrollee experiences a problem with the managed care organization or its providers, and appeal rights under section 256.045.

Sec. 14. **[256N.19] MONITORING AND EVALUATION OF QUALITY AND COSTS.**

(a) The commissioner, as a condition of contract, shall require each participating managed care organization and participating provider to submit, in the form and manner specified by the commissioner, data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services. The commissioner shall evaluate this data, in order to:

(1) make summary information on the quality of care across managed care organizations, medical clinics, and providers available to consumers;

(2) require managed care organizations and providers, as a condition of contract, to implement quality improvement plans; and

(3) compare the cost and quality of services under the program to the cost and quality of services provided to private sector enrollees.

(b) The commissioner shall implement this section to the extent allowed by federal and state laws on data privacy.

Sec. 15. **[256N.21] FEDERAL APPROVAL.**

The commissioner shall seek all federal waivers and approvals necessary to implement this chapter including, but not limited to, waivers and approvals necessary to:

(1) coordinate medical assistance and MinnesotaCare coverage for children with the children's health security program;

(2) use federal medical assistance and MinnesotaCare dollars to pay for health care services under the children's health security program;

(3) 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;

(4) extend presumptive eligibility and continuous eligibility to children under age 21; and

(5) use federal medical assistance and MinnesotaCare dollars to provide benefits to dependent children.

Sec. 16. **[256N.23] RULEMAKING.**

The commissioner shall adopt rules to implement this chapter.

Sec. 17. **[256N.25] CHILDREN'S HEALTH SECURITY PROGRAM OUTREACH.**

Subdivision 1. **Grant awards.** The commissioner shall award grants to public or private organizations to:

(1) provide information, in areas of the state with high uninsured populations, on the importance of maintaining insurance coverage and on how to obtain coverage through the children's health security program; and

(2) monitor and provide ongoing support to ensure enrolled children remain covered.

Subd. 2. **Criteria.** In awarding the grants, the commissioner shall consider the following:

(1) geographic areas and populations with high uninsured rates;

(2) the ability to raise matching funds;

(3) the ability to contact, effectively communicate with, or serve eligible populations; and

(4) the applicant's plan to monitor and provide support to ensure enrolled children remain covered.

Subd. 3. **Monitoring and termination.** The commissioner shall monitor the grants and may terminate a grant if the outreach effort does not increase enrollment in the children's health security program.

Sec. 18. **IMPLEMENTATION PLAN.**

The commissioner of human services shall develop an implementation plan for the children's health security coverage program, which includes a health delivery plan based on the criteria specified in Minnesota Statutes, section 256N.13, subdivision 1. The commissioner shall present this plan, any necessary draft legislation, and a draft of proposed rules to the legislature by December 15, 2007. The plan must include recommendations for any additional legislative changes necessary to merge medical assistance and MinnesotaCare coverage for children into the children's health security program. The commissioner shall evaluate the provision of services under the program to children with disabilities and shall present recommendations to the legislature by December 15, 2009, for any program changes necessary to ensure the quality and continuity of care.

Sec. 19. **LEGISLATIVE TASK FORCE ON CHILDREN'S HEALTH CARE COVERAGE.**

Subdivision 1. **Establishment; membership.** (a) The Legislative Task Force on Children's Health Care Coverage is established. The task force is made up of ten voting members and six nonvoting members.

(b) The voting members are:

(1) five members of the house of representatives, of whom three members must be appointed by the speaker of the house of representatives and two members must be appointed by the minority leader of the house of representatives; and

(2) five members of the senate, of whom three members must be appointed by the majority leader of the senate and two members appointed by the minority leader of the senate.

(c) The nonvoting members are one representative selected by each of the following organizations:

(1) the American Academy of Pediatrics, Minnesota Chapter;

(2) the Minnesota Nurses Association;

(3) the Minnesota Council of Health Plans;

(4) the Minnesota Children's Platform Coalition;

(5) the Minnesota Universal Health Care Coalition; and

(6) the Minnesota Business Partnership.

(d) The task force members must be appointed by September 1, 2007. The majority leader of the senate and the speaker of the house of representatives must each designate a chair from their appointments. The chair appointed by the speaker of the house of representatives shall convene and chair the first meeting of the task force. The chair appointed by the majority leader of the senate shall chair the next meeting of the task force. The chairs shall then alternate for the duration of the task force.

Subd. 2. **Study; staff support.** (a) The task force shall study viable options to extend coverage to all children as provided in Minnesota Statutes, section 256N.05, subdivision 2, paragraph (c), and provide recommendations to the legislature. The study must:

(1) evaluate methods to achieve universal coverage for children, including, but not limited to, changes to the employer-based coverage system and an expansion of eligibility for the children's health security program established under Minnesota Statutes, chapter 256N;

(2) examine health care reform and cost containment methods that will contain costs and increase access and improve health outcomes;

(3) examine how to increase access to preventive care and health care services; and

(4) examine how to reduce health disparities among minority populations.

(b) The task force, through the Legislative Coordinating Commission, may hire staff or contract for staff support for the study.

(c) The task force, in developing recommendations, shall hold meetings to hear public testimony at locations throughout the state, including locations outside of the seven-county metropolitan area.

Subd. 3. **Recommendations.** The task force shall report its recommendations to the legislature by December 15, 2008. Recommendations must be consistent with the following criteria:

(1) health care coverage must include preventive care and all other medically necessary services;

(2) health care coverage must be affordable for families, with the family share of premium costs and cost-sharing in total not exceeding five percent of family income;

(3) the system of coverage must give priority to ensuring access to and the quality and continuity of care; and

(4) enrollment must be simple and seamless for families.

Subd. 4. **Expiration.** This section expires December 16, 2008.

Sec. 20. **APPROPRIATION.**

(a) $..... is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 2009, to develop and implement the Children's Health Security Act under Minnesota Statutes, chapter 256N.

(b) $..... is appropriated from the health care access fund to the commissioner of human services for the biennium ending June 30, 2009, to develop and implement the Children's Health Security Act under Minnesota Statutes, chapter 256N.

(c) $..... is appropriated from the general fund to the Legislative Coordinating Commission for the biennium ending June 30, 2009, for staff support provided to the Legislative Task Force on Children's Health Care Coverage.