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State of Minnesota

Printed Page No. 563

HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH SESSION

HOUSE FILE NO. 3391

February 25, 2008
Authored by Huntley; Thissen; Loeffler; Bunn; Murphy, E., and others
The bill was read for the first time and referred to the Committee on Health and Human Services
March 4, 2008
Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Governmental Operations, Reform, Technology and Elections
March 6, 2008
Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Public Safety and Civil Justice
March 10, 2008
Committee Recommendation and Adoption of Report: To Pass and re-referred to the Committee on Commerce and Labor
March 13, 2008
Committee Recommendation and Adoption of Report: To Pass and re-referred to the Committee on Finance
April 2, 2008
Committee Recommendation and Adoption of Report: To Pass as Amended and re-referred to the Committee on Ways and Means
April 7, 2008
Committee Recommendation and Adoption of Report: To Pass as Amended and Read Second Time
April 10, 2008
Fiscal Calendar, Amended
Read Third Time as Amended
Passed by the House as Amended and transmitted to the Senate to include Floor Amendments

1.1 A bill for an act
1.2 relating to health care reform; increasing affordability and continuity of care
1.3 for state health care programs; modifying health care provisions; providing
1.4 subsidies for employee share of employer-subsidized insurance in certain
1.5 cases; establishing the Health Care Transformation Commission; creating an
1.6 affordability standard; implementing a statewide health improvement program;
1.7 requiring an evaluation of mandated health benefits; requiring a payment system
1.8 to encourage provider innovation; requiring studies and reports; appropriating
1.9 money; amending Minnesota Statutes 2006, sections 62Q.025, by adding
1.10 a subdivision; 256.01, subdivision 18; 256B.056, by adding a subdivision;
1.11 256B.057, subdivision 8; 256B.69, by adding a subdivision; 256L.05, by
1.12 adding a subdivision; 256L.06, subdivision 3; 256L.07, subdivision 3, by
1.13 adding a subdivision; 256L.15, by adding a subdivision; Minnesota Statutes
1.14 2007 Supplement, sections 256.01, subdivision 2b; 256B.056, subdivision 10;
1.15 256L.03, subdivisions 3, 5; 256L.04, subdivisions 1, 7; 256L.05, subdivision
1.16 3a; 256L.07, subdivision 1; 256L.15, subdivision 2; proposing coding for new
1.17 law in Minnesota Statutes, chapters 145; 256B; proposing coding for new law
1.18 as Minnesota Statutes, chapter 62U; repealing Minnesota Statutes 2006, section
1.19 256L.15, subdivision 3.

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

1.21 **ARTICLE 1**

1.22 **HEALTH CARE HOMES**

1.23 Section 1. Minnesota Statutes 2007 Supplement, section 256.01, subdivision 2b,
1.24 is amended to read:

1.25 Subd. 2b. **Performance payments.** (a) The commissioner shall develop and
1.26 implement a pay-for-performance system to provide performance payments to eligible
1.27 medical groups and clinics that demonstrate optimum care in serving individuals
1.28 with chronic diseases who are enrolled in health care programs administered by the
1.29 commissioner under chapters 256B, 256D, and 256L. The commissioner may receive any
1.30 federal matching money that is made available through the medical assistance program

2.1 for managed care oversight contracted through vendors, including consumer surveys,
2.2 studies, and external quality reviews as required by the federal Balanced Budget Act of
2.3 1997, Code of Federal Regulations, title 42, part 438-managed care, subpart E-external
2.4 quality review. Any federal money received for managed care oversight is appropriated
2.5 to the commissioner for this purpose. The commissioner may expend the federal money
2.6 received in either year of the biennium.

2.7 (b) Effective July 1, 2009, or upon federal approval, whichever is later, the
2.8 commissioner shall develop and implement a patient incentive health program to provide
2.9 incentives and rewards to patients who are enrolled in health care programs administered
2.10 by the commissioner under chapters 256B, 256D, and 256L, and who have agreed to
2.11 and have met personal health goals established with the patients' primary care providers
2.12 to manage a chronic disease or condition, including but not limited to diabetes, high
2.13 blood pressure, and coronary artery disease. The commissioner shall collaborate with the
2.14 commissioner of health and with community-based organizations that conduct chronic
2.15 disease consumer education programs targeted at labor, business, faith-based, and health
2.16 care constituencies to avoid duplication of efforts.

2.17 Sec. 2. **[256B.0431] ENROLLEE REQUIREMENTS RELATED TO HEALTH**
2.18 **CARE HOMES.**

2.19 Subdivision 1. **Selection of primary care clinic.** Beginning January 1, 2009, the
2.20 commissioner shall encourage state health care program enrollees eligible for services
2.21 under the fee-for-service system to select a primary care clinic or medical group, within
2.22 two months of enrollment. Beginning July 1, 2009, the commissioner shall encourage
2.23 enrollees who have a complex or chronic condition to select a primary care clinic or
2.24 medical group with clinicians who have been certified as health care homes under section
2.25 256B.0751, subdivision 3. The commissioner and county social service agencies shall
2.26 provide enrollees with lists of primary care clinics, medical groups, and clinicians certified
2.27 as health care homes, and shall establish a toll-free number to provide enrollees with
2.28 assistance in choosing a clinic, medical group, or health care home.

2.29 Subd. 2. **Initial health assessment.** The commissioner shall encourage state health
2.30 care program enrollees eligible for services under the fee-for-service system to obtain an
2.31 initial health assessment at their selected primary care clinic or medical group, within
2.32 one month of selection, in order to identify individuals with complex or chronic health
2.33 conditions, and to identify preventative health care needs.

2.34 Subd. 3. **Education and outreach.** Beginning January 1, 2009, the commissioner
2.35 shall provide patient education and outreach to state health care program enrollees and

3.1 applicants related to the importance of choosing a primary care clinic or medical group
3.2 and a health care home. Education and outreach must be targeted to underserved or special
3.3 populations. The commissioner shall also develop and implement an outreach program to
3.4 enroll eligible persons in state health care programs, by providing a per enrollee bonus
3.5 to licensed producers under chapter 60K and nonprofit health care or social service
3.6 organizations who provide assistance in enrolling applicants.

3.7 Subd. 4. **State health care program.** For purposes of this section, "state health
3.8 care program" means the medical assistance, MinnesotaCare, and general assistance
3.9 medical care programs.

3.10 Sec. 3. **[256B.0751] HEALTH CARE HOMES; DEFINITIONS;**
3.11 **ESTABLISHMENT.**

3.12 Subdivision 1. **Definitions.** (a) For purposes of sections 256B.0751 to 256B.0754,
3.13 the definitions in this subdivision apply.

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

3.15 (c) "Commissioners" means the commissioner of human services and the
3.16 commissioner of health acting jointly.

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

3.19 Subd. 2. **Establishment of health care homes.** The commissioners shall establish
3.20 health care homes for state health care program enrollees who have complex or chronic
3.21 health conditions. The requirements for health care homes must be consistent with the
3.22 standards developed by a nationally recognized independent accrediting organization. In
3.23 establishing health care homes, the commissioners shall consider and, when appropriate,
3.24 incorporate features of the medical home model developed for the provider-directed
3.25 care coordination program authorized under section 256B.0625, subdivision 51, and
3.26 features of the proposals for integrated community initiatives developed in response to
3.27 Laws 2007, chapter 147, article 15, section 18, subdivision 2. The commissioner shall
3.28 study the feasibility of expanding health care homes to all enrollees and report to the
3.29 legislature by January 1, 2011.

3.30 Subd. 3. **Certification.** By July 1, 2009, the commissioners shall begin certification
3.31 of individual clinicians, who participate as providers in state health care programs and
3.32 meet the requirements of section 256B.0752, as health care homes. Clinicians may enter
3.33 into collaborative agreements with other clinicians to develop the components of a health
3.34 care home. Clinician certification as a health care home is voluntary. Clinicians certified
3.35 as health care homes shall renew their certification annually, in order to maintain their

4.1 status as health care homes. The commissioner may waive some requirements in order to
4.2 certify providers and clinicians with health care home models in existence on March 1,
4.3 2008, that serve special patient populations of diverse race, language, or ethnicity.

4.4 Sec. 4. **[256B.0752] HEALTH CARE HOME REQUIREMENTS.**

4.5 Subdivision 1. **Requirement.** In order to be certified as a health care home, a
4.6 clinician shall meet the criteria specified in this section and section 256B.0751.

4.7 Subd. 2. **Patient-provider relationship; care teams.** Each patient of a health care
4.8 home shall have an ongoing relationship with a provider trained as a personal clinician
4.9 to provide first contact, continuous, and comprehensive care for a patient's health care
4.10 needs. Appropriate specialists and other health care professionals who do not practice in
4.11 a traditional primary care field, physician's assistants, and advanced practice registered
4.12 nurses shall be allowed to serve as personal clinicians, if they provide care according
4.13 to this section.

4.14 Subd. 3. **Care coordination.** (a) The personal clinician, in coordination with other
4.15 health care providers, is responsible for providing or monitoring the patient's health
4.16 care needs or for arranging, or assisting with arrangements for, appropriate care with
4.17 other qualified professionals. Health care must be coordinated across all provider types,
4.18 all care locations, and the greater community. This coordination applies to care for all
4.19 stages of life, including preventive care, acute care, chronic care, and end-of-life care.
4.20 Care coordination must include ongoing planning to prepare for patient transitions across
4.21 different types of care and provider types. The care team shall also coordinate with those
4.22 providing for the social service needs of the individual, if this is necessary to ensure a
4.23 successful health outcome. Care coordination must be provided in a manner appropriate to
4.24 the patient's race, ethnicity, and language. A personal clinician and care team may utilize
4.25 county health care and social service providers to satisfy these requirements.

4.26 (b) Selection of a health care home does not limit a patient's ability to seek care
4.27 from other providers.

4.28 Subd. 4. **Care delivery.** (a) A health care home must provide or arrange for access
4.29 to care 24 hours a day, seven days a week.

4.30 (b) Health care homes must encourage the patient, and when authorized and
4.31 appropriate, the family or a legally recognized person as defined in chapter 145C, to
4.32 actively participate in decision making as a full member of the primary care team. Health
4.33 care homes must consider patients and families as partners in decision making, and must
4.34 provide access to a patient-directed, decision-making process, including appropriate
4.35 decision aids, when available.

5.1 (c) Care delivery must be facilitated by the use of health information technology and
5.2 through systematic patient follow-up using internal clinic patient registries, according to
5.3 minimum standards specified by the commissioners. A health care home must obtain a
5.4 patient's written consent prior to making the patient's medical records available through
5.5 the Internet.

5.6 (d) Care must be provided in a culturally and linguistically appropriate manner.

5.7 (e) Within the context of a system of continuous quality improvement, care
5.8 delivery, whenever possible, must be based on evidence-based medicine and use clinical
5.9 decision-support tools.

5.10 (f) A health care home must provide enhanced access to care, using methods such
5.11 as open scheduling, expanded hours, and new communication methods, such as e-mail,
5.12 phone consultations, and e-consults.

5.13 (g) Providers certified as health care homes must offer their health care home
5.14 services to all their patients with complex or chronic health conditions who are interested
5.15 in participation.

5.16 Subd. 5. **Quality of care.** Health care homes must meet process, outcome, and
5.17 quality standards as developed and specified by the commissioners. Health care homes
5.18 must measure and publicly report all data necessary for the commissioners to monitor
5.19 compliance with these standards.

5.20 Subd. 6. **Comprehensive care plan.** Health care homes must develop, maintain,
5.21 and ensure the implementation of a comprehensive care plan for each enrollee who
5.22 has a complex or chronic condition, based upon health history, tests, assessments, and
5.23 other information. The comprehensive care plan must meet the criteria specified by the
5.24 commissioners. The comprehensive care plan must be culturally appropriate.

5.25 Subd. 7. **Care coordinators.** Health care homes must utilize care coordinators
5.26 to manage the care provided to patients with complex or chronic conditions. Care
5.27 coordinators must be trained to provide services that are appropriate for the race, ethnicity,
5.28 and language of the patient. Care coordination includes:

5.29 (1) identifying patients with complex or chronic conditions eligible for care
5.30 coordination;

5.31 (2) assisting primary care providers in care coordination and education;

5.32 (3) helping patients coordinate their care or access needed services, including
5.33 preventative care;

5.34 (4) communicating the care needs and concerns of the patient to the health care home;

5.35 (5) collecting data on process and outcome measures;

5.36 (6) overseeing the development, maintenance, and implementation of care plans; and

6.1 (7) meeting other criteria as specified by the commissioner.

6.2 Subd. 8. **Health care home collaborative.** Health care homes must participate
6.3 in the health care home collaborative defined in section 256B.0754, subdivision 4, as
6.4 required by the commissioners for certification.

6.5 Sec. 5. **[256B.0753] CARE COORDINATION FEE.**

6.6 Subdivision 1. **Care coordination fee.** (a) The commissioner shall pay each health
6.7 care home a per-person per-month care coordination fee for providing care coordination
6.8 services. The fee must be paid for each fee-for-service state health care program enrollee
6.9 eligible for a health care home, who is served by a personal clinician certified as a health
6.10 care home.

6.11 (b) Payment of the care coordination fee is contingent on the health care home
6.12 meeting the certification standards for health care homes. The care coordination fee is in
6.13 addition to reimbursement received by a health care home under the medical assistance
6.14 fee-for-service payment system for health care services.

6.15 Subd. 2. **Amount of fee.** The care coordination fee must be determined by the
6.16 commissioner in contracts with health care homes, and must vary by thresholds of care
6.17 complexity, with the highest fees being paid for care provided to individuals requiring the
6.18 most intensive care coordination, such as those with very complex health care needs or
6.19 several chronic conditions and those who face racial, ethnic, or language barriers.

6.20 Subd. 3. **Cost neutrality.** If initial savings from implementation of health care
6.21 homes are not sufficient to allow implementation of the care coordination fee in a
6.22 cost-neutral manner, the commissioner shall reallocate costs within the health care system.

6.23 **EFFECTIVE DATE.** Subdivisions 1 and 2 are effective July 1, 2009, or upon
6.24 federal approval, whichever is later.

6.25 Sec. 6. **[256B.0754] DUTIES OF THE COMMISSIONERS.**

6.26 Subdivision 1. **Establishment of certification standards and other criteria.** (a)
6.27 By January 1, 2009, the commissioners shall establish certification standards for health
6.28 care homes consistent with the criteria in section 256B.0752.

6.29 (b) By January 1, 2009, the commissioners shall develop care complexity thresholds
6.30 and payment amounts for the care coordination fee established under section 256B.0753.

6.31 (c) By January 1, 2009, the commissioners shall identify criteria to determine
6.32 enrollees eligible for and in need of care coordination, and who would benefit from having
6.33 a comprehensive care plan for their condition.

7.1 (d) By January 1, 2009, the commissioners shall establish criteria and data collection
7.2 procedures for evaluating health care homes.
7.3 (e) By January 1, 2009, the commissioners shall develop health care home
7.4 requirements for managed care plan contracts, performance incentives, and withholds,
7.5 and shall develop the methodology for identifying and recapturing managed care savings
7.6 resulting from implementation of the health care home model.
7.7 (f) The commissioners shall adopt rules to implement the standards, thresholds,
7.8 payment amounts, criteria, procedures, requirements, and methodology required under
7.9 paragraphs (a) to (e).
7.10 Subd. 2. **Monitoring and evaluation.** The commissioners shall ensure the
7.11 collection from health care homes of data necessary to monitor implementation of the
7.12 health care home model, measure and evaluate quality of care and outcomes, measure
7.13 and evaluate patient experience, and determine cost savings from implementation of
7.14 the health care home model. The commissioners shall collect and evaluate this data
7.15 directly, but may contract with an appropriate private sector entity for technical assistance.
7.16 The commissioners shall provide health care homes with practice profiles measuring
7.17 utilization, cost, and quality. Quality measures must include measures of disparities in
7.18 treatment, health status, and outcomes based on race, ethnicity, or language.
7.19 Subd. 3. **Care Coordination Advisory Committee.** By July 1, 2008, the
7.20 commissioners shall establish a Care Coordination Advisory Committee to assist the
7.21 Departments of Human Services and Health in administering the health care home model,
7.22 developing the criteria and standards required under subdivision 1, collecting data,
7.23 and measuring and evaluating health outcomes and cost savings. The commissioners
7.24 may satisfy this requirement by continuing the advisory committee established for the
7.25 provider-directed care coordination program. If newly established, the committee must
7.26 include representatives of: primary care and specialist physicians, advanced practice
7.27 registered nurses, patients and their families including minority ethnic groups, health
7.28 plans, providers serving low-income and culturally diverse populations, organizations with
7.29 expertise in care coordination models, and other relevant entities. If newly established,
7.30 membership terms and compensation and removal of members are governed by section
7.31 15.059. The committee does not expire.
7.32 Subd. 4. **Health care home collaborative.** By July 1, 2009, the commissioners
7.33 shall establish a health care home collaborative to provide an opportunity for health care
7.34 homes and state agencies to exchange information related to quality improvement and
7.35 best practices.

8.1 Subd. 5. **Patient-directed, decision-making process.** By January 1, 2009,
8.2 the commissioners, in consultation with the Care Coordination Advisory Committee
8.3 and the Institute of Clinical Systems Improvement, shall develop a patient-directed,
8.4 decision-making support model to be used by health care homes. The commissioners shall:

8.5 (1) establish protocols that include identifying the use of a patient-directed,
8.6 culturally appropriate decision-making process and effectively incorporating the use of
8.7 patient-decision aids, when appropriate;

8.8 (2) ensure the quality of the patient-decision aids available to the patient;

8.9 (3) ensure accessibility and cultural appropriateness of the patient-decision aids,
8.10 including the use of language interpreters, when necessary; and

8.11 (4) ensure that providers are trained to use patient-decision aids effectively.

8.12 Subd. 6. **Report on standards; annual reports.** (a) By November 15, 2008, the
8.13 commissioners must report drafts of certification standards, care complexity thresholds,
8.14 and other criteria, procedures, and payment amounts necessary to implement subdivision
8.15 1 to the chairs and lead minority members of the legislative committees with jurisdiction
8.16 over health care policy and finance. These standards, thresholds, criteria, procedures, and
8.17 payment amount are not subject to chapter 14, and section 14.386 does not apply.

8.18 (b) The commissioners shall report annually to the legislature on the implementation
8.19 and administration of the health care home model for state health care program enrollees
8.20 in the fee-for-service, managed care, and county-based purchasing sectors, beginning
8.21 December 15, 2009, and each December 15 thereafter. The report must include: (1)
8.22 information on the number of state health care program enrollees in health care homes; (2)
8.23 the number and characteristics of enrollees with complex or chronic conditions, broken
8.24 down by income, race, ethnicity, and language whenever possible; (3) the number and
8.25 geographic distribution of health care home providers; (4) the performance and quality
8.26 of care of health care homes; (5) measures of preventative care; (6) costs related to
8.27 implementation and payment of care coordination fees; (7) health care home payment
8.28 arrangements; (8) the estimated impact on health disparities; (9) estimates of savings from
8.29 implementation of the health care home model for the fee-for-service, managed care, and
8.30 county-based purchasing sectors relative to the health care spending baseline calculated
8.31 under section 62U.07; and (10) any criteria waived under section 256B.69, subdivision
8.32 29, paragraph (a).

8.33 Sec. 7. Minnesota Statutes 2006, section 256B.69, is amended by adding a subdivision
8.34 to read:

9.1 Subd. 29. **Health care home model.** (a) The commissioner shall require
9.2 demonstration providers, as a condition of contract, to adopt by July 1, 2009, a health care
9.3 home model for providing care to state health care program enrollees. The health care
9.4 home model must meet the criteria specified in this section and section 256B.0752. The
9.5 commissioner, in consultation with the commissioner of health, may waive or modify
9.6 criteria for demonstration providers if the commissioners of health and human services
9.7 determine that performance and quality standards would still be met.
9.8 (b) The commissioner, as a condition of contract, shall require demonstration
9.9 providers, as part of their implementation of the health care home model, to pay providers
9.10 a care coordination fee. The care coordination fee must meet the requirements of section
9.11 256B.0753. Demonstration providers shall fund the care coordination fee through savings
9.12 that result from implementation of the health care home model and, if necessary, through
9.13 reductions in administrative costs and reallocation of other payment rates within its
9.14 network. The commissioner shall not adjust current or future capitation rates for costs
9.15 related to payment of the care coordination fee.
9.16 (c) The commissioners of health and human services shall require demonstration
9.17 providers to: (1) collect from health care homes the data necessary to monitor
9.18 implementation of the health care home model, measure and evaluate quality of care
9.19 and outcomes, measure and evaluate patient experience, and determine cost savings
9.20 from implementation of the health care home model; and (2) submit this data to
9.21 the commissioners. The commissioners of health and human services shall provide
9.22 demonstration providers and health care homes with practice profiles measuring
9.23 utilization, cost, and quality. Before establishing or amending general standards for data
9.24 collection under this paragraph, the commissioners must report the draft standards to the
9.25 chairs and lead minority members of the legislative committees with jurisdiction over
9.26 health care policy and finance, to the chairs and lead minority members of the legislative
9.27 committees with jurisdiction over data practices, and to the Information Policy Analysis
9.28 Division of the Department of Administration. Standards for data collection are not
9.29 subject to chapter 14 and section 14.386 does not apply.
9.30 (d) The commissioner shall study the feasibility and method of calculating savings
9.31 from the use of health care homes, as required in section 256B.0754, subdivision 6,
9.32 paragraph (b). The study must consider the methodology for distribution of savings.
9.33 Under the methodology, the state must retain one-half of the savings, the demonstration
9.34 providers may retain up to one-fourth of the savings, and at least one-fourth of the savings
9.35 must be passed on to health care providers in the form of higher payment rates.

10.1 (e) Demonstration providers must encourage state health care program enrollees to
10.2 complete an initial health assessment within three months from the time of enrollment, in
10.3 order to identify individuals with complex or chronic health conditions, and to identify
10.4 preventative health care needs.
10.5 (f) Beginning July 1, 2009, the commissioner shall require demonstration providers
10.6 to require health care homes to develop, maintain, and ensure the implementation of a
10.7 comprehensive care plan, as defined in section 256B.0752, subdivision 6.
10.8 (g) Beginning July 1, 2009, the commissioner shall implement financial
10.9 arrangements for demonstration providers to ensure that plans encourage each enrollee
10.10 who has a complex or chronic condition to choose a certified primary care clinic or
10.11 medical group to serve as a health care home.

10.12 Sec. 8. **PAYMENT OF CARE COORDINATION FEE UNDER STATE**
10.13 **MANAGED CARE PROGRAMS.**
10.14 The commissioner of human services shall study the feasibility of paying the
10.15 care coordination fee required under Minnesota Statutes, section 256B.69, subdivision
10.16 29, paragraph (b), directly to health care providers under contract with demonstration
10.17 providers to serve state health care program enrollees, and shall present recommendations
10.18 to the legislature by December 15, 2008.

10.19 Sec. 9. **WORKFORCE SHORTAGE STUDY.**
10.20 To address health care workforce shortages, the Health Care Transformation
10.21 Commission, in consultation with health licensing boards and professional associations,
10.22 shall study changes necessary in health professional licensure and regulation to ensure
10.23 full utilization of advanced practice registered nurses, physician's assistants, oral health
10.24 professionals, and other licensed health care professionals in the health care home and
10.25 primary delivery system. The Health Care Transformation Commission shall make
10.26 recommendations to the legislature by January 15, 2009.

10.27 Sec. 10. **HEALTH CARE ACCESS FUND TRANSFER.**
10.28 On July 1, 2008, the commissioner of finance shall transfer $1,390,000 from the
10.29 health care access fund to the general fund. On July 1, 2009, the commissioner of finance
10.30 shall transfer $1,777,000 from the health care access fund to the general fund. On July 1,
10.31 2010, the commissioner of finance shall transfer $3,258,000 from the health care access
10.32 fund to the general fund.

11.1 **ARTICLE 2**

11.2 **INCREASING ACCESS; CONTINUITY OF CARE**

11.3 Section 1. Minnesota Statutes 2006, section 256.01, subdivision 18, is amended to read:

11.4 Subd. 18. **Immigration status verifications.** (a) Notwithstanding any waiver of
11.5 this requirement by the secretary of the United States Department of Health and Human
11.6 Services, effective July 1, 2001, the commissioner shall utilize the Systematic Alien
11.7 Verification for Entitlements (SAVE) program to conduct immigration status verifications:

11.8 (1) as required under United States Code, title 8, section 1642;

11.9 (2) for all applicants for food assistance benefits, whether under the federal food
11.10 stamp program, the MFIP or work first program, or the Minnesota food assistance program;

11.11 (3) for all applicants for general assistance medical care, except assistance for an
11.12 emergency medical condition, for immunization with respect to an immunizable disease,
11.13 or for testing and treatment of symptoms of a communicable disease, and for nonfederally
11.14 funded MinnesotaCare; and

11.15 (4) for all applicants for general assistance, Minnesota supplemental aid, medical
11.16 assistance, federally funded MinnesotaCare, or group residential housing, when the
11.17 benefits provided by these programs would fall under the definition of "federal public
11.18 benefit" under United States Code, title 8, section 1642, if federal funds were used to
11.19 pay for all or part of the benefits.

11.20 (b) The commissioner shall comply with the reporting requirements under United
11.21 States Code, title 42, section 611a, and any federal regulation or guidance adopted under
11.22 that law.

11.23 **EFFECTIVE DATE.** This section is effective July 1, 2009.

11.24 Sec. 2. Minnesota Statutes 2007 Supplement, section 256B.056, subdivision 10,
11.25 is amended to read:

11.26 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who
11.27 are applying for the continuation of medical assistance coverage following the end of the
11.28 60-day postpartum period to update their income and asset information and to submit
11.29 any required income or asset verification.

11.30 (b) The commissioner shall determine the eligibility of private-sector health care
11.31 coverage for infants less than one year of age eligible under section 256B.055, subdivision
11.32 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage
11.33 if this is determined to be cost-effective.

12.1 (c) The commissioner shall verify ~~assets and~~ income for all applicants, and for all
12.2 recipients upon renewal. The commissioner shall verify liquid assets for applicants, and
12.3 for recipients upon renewal, only if the applicant or recipient reports total countable
12.4 assets within ten percent of the applicable asset limit. The commissioner may verify
12.5 nonliquid assets, but is not required to do so. This paragraph does not apply to applicants
12.6 or recipients applying for or receiving medical assistance payment of long-term care
12.7 services, including services under section 256B.0915, 256B.092, or 256B.49.
12.8 (d) The commissioner shall designate locations where enrollees may submit renewal
12.9 forms, including but not limited to community clinics and health care providers' offices.
12.10 The designated sites shall forward the renewal forms to the commissioner.

12.11 **EFFECTIVE DATE.** The amendment to paragraph (c) is effective January 1, 2009.

12.12 Sec. 3. Minnesota Statutes 2006, section 256B.056, is amended by adding a
12.13 subdivision to read:
12.14 Subd. 12. **Eligibility; drug testing.** (a) To be eligible for medical assistance, an
12.15 applicant or participant who has been convicted of a drug offense committed after July
12.16 1, 1997, may receive medical assistance benefits unless:
12.17 (1) the convicted applicant tests positive for an illegal controlled substance in which
12.18 case the applicant is subject to a one-time fee equal to $150; and
12.19 (2) for a second positive test result for illegal controlled substance the participant is
12.20 permanently disqualified from medical assistance.

12.21 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
12.22 approval, whichever is later.

12.23 Sec. 4. Minnesota Statutes 2006, section 256B.057, subdivision 8, is amended to read:
12.24 Subd. 8. **Children under age two.** Medical assistance may be paid for a child under
12.25 two years of age whose countable family income is above 275 percent of the federal
12.26 poverty guidelines for the same size family but less than or equal to ~~280~~ 305 percent of the
12.27 federal poverty guidelines for the same size family.

12.28 **EFFECTIVE DATE.** This section is effective January 1, 2010, or upon federal
12.29 approval, whichever is later.

12.30 Sec. 5. Minnesota Statutes 2007 Supplement, section 256L.03, subdivision 3, is
12.31 amended to read:

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. The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant, is subject to an annual limit of ~~$10,000~~ $20,000.

(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.

EFFECTIVE DATE. This section is effective July 1, 2009, for single adults and households with no children enrolled under section 256L.07, subdivision 4, and is effective July 1, 2009, or upon federal approval, whichever is later, for adults in families with children enrolled under section 256L.04, subdivision 1. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2007 Supplement, section 256L.03, subdivision 5, is amended to read:

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

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual and $3,000 per family;

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or

14.1 established illness, and which is delivered in an ambulatory setting by a physician or
14.2 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
14.3 audiologist, optician, or optometrist; and

14.4 (5) $6 for nonemergency visits to a hospital-based emergency room.

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

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

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

14.9 (e) Adult enrollees with family gross income that exceeds 200 percent of the federal
14.10 poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009,
14.11 and who are not pregnant shall be financially responsible for the coinsurance amount, if
14.12 applicable, and amounts which exceed the ~~$10,000~~ $20,000 inpatient hospital benefit limit.

14.13 (f) When a MinnesotaCare enrollee becomes a member of a prepaid health
14.14 plan, or changes from one prepaid health plan to another during a calendar year, any
14.15 charges submitted towards the ~~$10,000~~ $20,000 annual inpatient benefit limit, and any
14.16 out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted
14.17 or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

14.18 **EFFECTIVE DATE.** This section is effective January 1, 2009, for single adults
14.19 and households with no children enrolled under section 256L.04, subdivision 7, and is
14.20 effective July 1, 2009, or upon federal approval, whichever is later, for adults in families
14.21 with children enrolled under section 256L.04, subdivision 1. The commissioner of human
14.22 services shall notify the revisor of statutes when federal approval is obtained.

14.23 Sec. 7. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 1, is
14.24 amended to read:

14.25 Subdivision 1. **Families with children.** (a) Families with children with family
14.26 income equal to or less than ~~275~~ 300 percent of the federal poverty guidelines for the
14.27 applicable family size shall be eligible for MinnesotaCare according to this section. All
14.28 other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers
14.29 to enrollment under section 256L.07, shall apply unless otherwise specified.

14.30 (b) Parents who enroll in the MinnesotaCare program must also enroll their children,
14.31 if the children are eligible. Children may be enrolled separately without enrollment by
14.32 parents. However, if one parent in the household enrolls, both parents must enroll, unless
14.33 other insurance is available. If one child from a family is enrolled, all children must
14.34 be enrolled, unless other insurance is available. If one spouse in a household enrolls,

15.1 the other spouse in the household must also enroll, unless other insurance is available.
15.2 Families cannot choose to enroll only certain uninsured members.

15.3 (c) Beginning October 1, 2003, the dependent sibling definition no longer applies
15.4 to the MinnesotaCare program. These persons are no longer counted in the parental
15.5 household and may apply as a separate household.

15.6 (d) ~~Beginning July 1, 2003, or upon federal approval, whichever is later, parents are~~
15.7 ~~not eligible for MinnesotaCare if their gross income exceeds $50,000.~~

15.8 ~~(e)~~ Children formerly enrolled in medical assistance and automatically deemed
15.9 eligible for MinnesotaCare according to section 256B.057, subdivision 2c, are exempt
15.10 from the requirements of this section until renewal.

15.11 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
15.12 approval, whichever is later. The commissioner of human services shall notify the revisor
15.13 of statutes when federal approval is obtained.

15.14 Sec. 8. Minnesota Statutes 2007 Supplement, section 256L.04, subdivision 7, is
15.15 amended to read:

15.16 Subd. 7. **Single adults and households with no children.** The definition of eligible
15.17 persons includes all individuals and households with no children who have gross family
15.18 incomes that are equal to or less than 200 percent of the federal poverty guidelines.
15.19 Effective July 1, 2009, the definition of eligible persons includes all individuals and
15.20 households with no children who have gross family incomes that are equal to or less than
15.21 ~~215~~ 300 percent of the federal poverty guidelines.

15.22 **EFFECTIVE DATE.** This section is effective July 1, 2009.

15.23 Sec. 9. Minnesota Statutes 2007 Supplement, section 256L.05, subdivision 3a, is
15.24 amended to read:

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

15.28 (b) Each new period of eligibility must take into account any changes in
15.29 circumstances that impact eligibility and premium amount. An enrollee must provide all
15.30 the information needed to redetermine eligibility by the first day of the month that ends the
15.31 eligibility period. The commissioner shall designate locations where enrollees may submit
15.32 renewal forms, including but not limited to community clinics and health care providers'
15.33 offices. The designated sites shall forward the renewal forms to the commissioner. The

16.1 premium for the new period of eligibility must be received as provided in section 256L.06
16.2 in order for eligibility to continue.

16.3 (c) For single adults and households with no children formerly enrolled in general
16.4 assistance medical care and enrolled in MinnesotaCare according to section 256D.03,
16.5 subdivision 3, the first period of eligibility begins the month the enrollee submitted the
16.6 application or renewal for general assistance medical care.

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

16.12 **EFFECTIVE DATE.** This section is effective January 1, 2010, or upon federal
16.13 approval, whichever is later. The commissioner of human services shall notify the revisor
16.14 of statutes when federal approval is obtained.

16.15 Sec. 10. Minnesota Statutes 2006, section 256L.05, is amended by adding a subdivision
16.16 to read:

16.17 Subd. 6. **Delayed verification.** On the basis of information provided on the
16.18 completed application, an applicant whose gross income is less than 90 percent of
16.19 the applicable income standard and meets all other eligibility requirements, including
16.20 compliance at the time of application with citizenship or nationality documentation
16.21 requirements under section 256L.04, subdivision 10, must be determined eligible and
16.22 enrolled upon payment of premiums according to subdivision 3. The applicant shall
16.23 provide all required verifications within 60 days' notice of the eligibility determination,
16.24 or eligibility shall be denied or cancelled. Applicants who are denied or cancelled for
16.25 failure to provide all required verifications are not eligible for coverage using the delayed
16.26 verification procedures specified in this subdivision for 12 months.

16.27 **EFFECTIVE DATE.** This section is effective January 1, 2010, or upon federal
16.28 approval, whichever is later. The commissioner of human services shall notify the revisor
16.29 of statutes when federal approval is obtained.

16.30 Sec. 11. Minnesota Statutes 2006, section 256L.06, subdivision 3, is amended to read:

16.31 Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the
16.32 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 first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. ~~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~~ The commissioner shall waive premiums for coverage provided under this paragraph to persons disenrolled for nonpayment who reapply under section 256L.05, subdivision 3b. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

EFFECTIVE DATE. This section is effective January 1, 2010, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 12. Minnesota Statutes 2007 Supplement, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the

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

Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above ~~275~~ 300 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or ~~215~~ 300 percent of the federal poverty guidelines on or after ~~July~~ January 1, 2009, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

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

~~(c) Notwithstanding paragraphs (a) and (b), parents are not eligible for MinnesotaCare if gross household income exceeds $50,000 for the 12-month period of eligibility.~~

EFFECTIVE DATE. This section is effective July 1, 2009, or upon federal approval, whichever is later, except that the amendment to paragraph (a) related to the four-month requirement is effective January 1, 2010, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

19.1 Sec. 13. Minnesota Statutes 2006, section 256L.07, subdivision 3, is amended to read:
19.2 Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the
19.3 MinnesotaCare program must have no health coverage while enrolled ~~or for at least four~~
19.4 ~~months prior to application and renewal~~. Children enrolled in the original children's health
19.5 plan and children in families with income equal to or less than 150 percent of the federal
19.6 poverty guidelines, who have other health insurance, are eligible if the coverage:
19.7 (1) lacks two or more of the following:
19.8 (i) basic hospital insurance;
19.9 (ii) medical-surgical insurance;
19.10 (iii) prescription drug coverage;
19.11 (iv) dental coverage; or
19.12 (v) vision coverage;
19.13 (2) requires a deductible of $100 or more per person per year; or
19.14 (3) lacks coverage because the child has exceeded the maximum coverage for a
19.15 particular diagnosis or the policy excludes a particular diagnosis.
19.16 The commissioner may change this eligibility criterion for sliding scale premiums
19.17 in order to remain within the limits of available appropriations. The requirement of no
19.18 health coverage does not apply to newborns.
19.19 (b) Medical assistance, general assistance medical care, and the Civilian Health and
19.20 Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under
19.21 United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or
19.22 health coverage for purposes of ~~the four-month requirement described in~~ this subdivision.
19.23 ~~(c)~~ For purposes of this subdivision, an applicant or enrollee who is entitled to
19.24 Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social
19.25 Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to
19.26 have health coverage. An applicant or enrollee who is entitled to premium-free Medicare
19.27 Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility
19.28 for MinnesotaCare.
19.29 ~~(d)~~ (c) Applicants who were recipients of medical assistance or general assistance
19.30 medical care within one month of application must meet the provisions of this subdivision
19.31 and subdivision 2.
19.32 ~~(e) Cost-effective health insurance that was paid for by medical assistance is not~~
19.33 ~~considered health coverage for purposes of the four-month requirement under this~~
19.34 ~~section, except if the insurance continued after medical assistance no longer considered it~~
19.35 ~~cost-effective or after medical assistance closed.~~

20.1 **EFFECTIVE DATE.** This section is effective January 1, 2010, or upon federal
20.2 approval, whichever is later. The commissioner of human services shall notify the revisor
20.3 of statutes when federal approval is obtained.

20.4 Sec. 14. Minnesota Statutes 2006, section 256L.07, is amended by adding a subdivision
20.5 to read:

20.6 Subd. 8. **Eligibility; drug testing.** (a) To be eligible for MinnesotaCare, an
20.7 applicant or participant who has been convicted of a drug offense committed after July 1,
20.8 1997, may receive MinnesotaCare benefits unless:

20.9 (1) the convicted applicant tests positive for an illegal controlled substance in which
20.10 case the applicant is subject to a one-time fee equal to $150; and

20.11 (2) for a second positive test result for illegal controlled substance the participant is
20.12 permanently disqualified from MinnesotaCare.

20.13 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
20.14 approval, whichever is later.

20.15 Sec. 15. Minnesota Statutes 2007 Supplement, section 256L.15, subdivision 2, is
20.16 amended to read:

20.17 Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The
20.18 commissioner shall establish a sliding fee scale to determine the percentage of monthly
20.19 gross individual or family income that households at different income levels must pay to
20.20 obtain coverage through the MinnesotaCare program. The sliding fee scale must be based
20.21 on the enrollee's monthly gross individual or family income. The sliding fee scale must
20.22 contain separate tables based on enrollment of one, two, or three or more persons. Until
20.23 June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross
20.24 individual or family income for individuals or families with incomes below the limits for
20.25 the medical assistance program for families and children in effect on January 1, 1999, and
20.26 proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and
20.27 8.8 percent. These percentages are matched to evenly spaced income steps ranging from
20.28 the medical assistance income limit for families and children in effect on January 1, 1999,
20.29 to 275 percent of the federal poverty guidelines for the applicable family size, up to a
20.30 family size of five. The sliding fee scale for a family of five must be used for families of
20.31 more than five. The sliding fee scale and percentages are not subject to the provisions of
20.32 chapter 14. If a family or individual reports increased income after enrollment, premiums
20.33 shall be adjusted at the time the change in income is reported.

21.1 (b) ~~Families~~ Children in families whose gross income is above ~~275~~ 300 percent
21.2 of the federal poverty guidelines shall pay the maximum premium. The maximum
21.3 premium is defined as a base charge for one, two, or three or more enrollees so that if all
21.4 MinnesotaCare cases paid the maximum premium, the total revenue would equal the
21.5 total cost of MinnesotaCare medical coverage and administration. In this calculation,
21.6 administrative costs shall be assumed to equal ten percent of the total. The costs of
21.7 medical coverage for pregnant women and children under age two and the enrollees in
21.8 these groups shall be excluded from the total. The maximum premium for two enrollees
21.9 shall be twice the maximum premium for one, and the maximum premium for three or
21.10 more enrollees shall be three times the maximum premium for one.
21.11 (c) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according
21.12 to the affordability scale established in section 62U.08 with the exception that children
21.13 in families with income at or below 150 percent of the federal poverty guidelines shall
21.14 pay a monthly premium of $4.

21.15 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
21.16 approval, whichever is later. The commissioner of human services shall notify the revisor
21.17 of statutes when federal approval is obtained.

21.18 Sec. 16. Minnesota Statutes 2006, section 256L.15, is amended by adding a subdivision
21.19 to read:
21.20 Subd. 5. **First month premium exemption.** New enrollee households are exempt
21.21 from premiums for the first month of MinnesotaCare enrollment. For purposes of this
21.22 exemption, a "new enrollee household" is a household which has not been enrolled in
21.23 MinnesotaCare for at least one year prior to application.

21.24 **EFFECTIVE DATE.** This section is effective January 1, 2010, or upon federal
21.25 approval, whichever is later. The commissioner of human services shall notify the revisor
21.26 of statutes when federal approval is obtained.

21.27 Sec. 17. **INSURANCE COVERAGE FOR LONG-TERM CARE WORKERS.**
21.28 (a) By December 15, 2008, the commissioner of human services shall study and
21.29 report to the legislature with recommendations for a rate increase to long-term care
21.30 employers dedicated to the purchase of employee health insurance in the private market.
21.31 The commissioner shall collect necessary actuarial data, employment data, current
21.32 coverage data, and other needed information.

22.1 (b) The commissioner shall develop cost estimates for three levels of insurance
22.2 coverage for long-term care workers:
22.3 (1) the coverage provided to state employees;
22.4 (2) the coverage provided to MinnesotaCare enrollees; and
22.5 (3) the benefits provided under an average private market insurance product, but
22.6 with a deductible limited to $100 per person.
22.7 Premium cost sharing, waiting periods for eligibility, definitions of full- and
22.8 part-time employment, and other parameters under the three options must be identical to
22.9 those under the state employees' health plan.
22.10 (c) For purposes of this section, a long-term care worker is a person employed by a
22.11 nursing facility, an intermediate care facility for persons with developmental disabilities,
22.12 or a service provider that:
22.13 (1) is eligible under Laws 2007, chapter 147, article 7, section 71; and
22.14 (2) provides long-term care services.
22.15 The commissioner may recommend a different definition of long-term care worker if
22.16 this definition presents insurmountable implementation issues.
22.17 (d) The recommendations must include measures to:
22.18 (1) ensure equitable treatment between employers that currently have different levels
22.19 of expenditure for employee health insurance costs; and
22.20 (2) enforce the requirement that the rate increase be expended for the intended
22.21 purpose.

22.22 Sec. 18. **REPEALER.**

22.23 Minnesota Statutes 2006, section 256L.15, subdivision 3, is repealed.

22.24 **EFFECTIVE DATE.** This section is effective July 1, 2009, or upon federal
22.25 approval of the amendments to section 15, whichever is later. The commissioner of human
22.26 services shall notify the revisor of statutes when federal approval is obtained.

22.27 Sec. 19. **APPROPRIATION.**

22.28 $804,000 is appropriated from the health care access fund to the commissioner
22.29 of human services for fiscal year 2009, to study insurance coverage for long-term care
22.30 workers under section 17.

ARTICLE 3
INSURANCE REFORM

Section 1. Minnesota Statutes 2006, section 62Q.025, is amended by adding a subdivision to read:

Subd. 3. **Premium rating of high deductible health plans.** A health plan company offering, issuing, or renewing high deductible health plans in the individual market in this state must annually analyze the relationships between the experience of those plans and the experience of its plans that are not high deductible health plans and make actuarially appropriate adjustments in its relative premium rates based upon those relative experiences. The health plan company must file the relative experience data and analysis with the commissioner when requesting approval of changes in premium rates.

Sec. 2. **UNIFORM OUTCOME MEASURES WORKING GROUP.**

(a) The Health Care Transformation Commission, established under Minnesota Statutes, section 62U.04, shall establish an informal working group to create a standardized limited set of measures by which to measure performance of health care providers for use in establishing statewide health improvement goals and in measuring progress on these goals. The group shall focus first on the most common areas of data collection for pay-for-performance systems.

(b) The working group must be known as the Uniform Outcome Measures Working Group. The commission shall determine its members and the number of members. The working group must include representatives of health care providers, health care purchasers, health insurers, public health agencies, and consumers.

(c) The working group shall attempt to determine uniform definitions, measures, and forms for submission of data, to the greatest extent possible. The uniform definitions and measures shall include mechanisms to adjust for patient health status and racial, ethnic, or language factors that affect quality outcomes.

(d) The working group shall seek to reduce the administrative burden on health care providers and health care purchasers.

(e) The working group shall invite and use the expertise of existing organizations experienced in health care quality measurement.

(f) The working group shall encourage participation by the public.

(g) The commission shall encourage use of the working group recommendations.

(h) By December 15, 2008, the commission shall provide to the legislature a written report under Minnesota Statutes, section 3.195, summarizing the work of the working

24.1 group. The report must include recommendations for: (1) a standardized set of health
24.2 care provider performance measures to be enacted by the legislature; (2) identification
24.3 of the evidence supporting each measure as an effective method of improving the
24.4 quality of patient care; and (3) a payment methodology to reduce capitation rates paid
24.5 by the commissioner of human services under Minnesota Statutes, section 256B.69, to
24.6 demonstration providers that use provider performance measures other than those included
24.7 in the standardized set under clause (1).

24.8 (i) The working group expires on June 30, 2009, unless the commission determines,
24.9 on an annual basis, that the group's continued existence would be beneficial.

24.10 Sec. 3. **COMMUNITY BENEFIT STANDARDS AND REPORTING;**
24.11 **NONPROFIT HEALTH PLAN COMPANIES; RECOMMENDATIONS.**

24.12 (a) By December 15, 2008, the commissioner of health shall recommend to the
24.13 legislature community benefit standards to be required by law of nonprofit health plan
24.14 companies doing business in the state. The expectations of the community benefits
24.15 provided and reported should be related to the statutory expectations in Minnesota
24.16 Statutes, sections 62C.01 and 62D.01, and thus focus on advocating public health,
24.17 improving the art and science of medical care, and addressing the need for financial
24.18 assistance to access ongoing coverage, and not related to general philanthropic endeavors.
24.19 The commissioner shall seek public input regarding the range of options to be explored
24.20 and the accountability measures.

24.21 (b) The recommendations must include a procedure by which each nonprofit health
24.22 plan company would periodically and uniformly report to the state and to the public
24.23 regarding the company's compliance with the requirements.

24.24 (c) The commissioner shall recommend a fair and effective enforcement and
24.25 remediation mechanism.

24.26 **ARTICLE 4**
24.27 **HEALTH INSURANCE PURCHASING AND AFFORDABILITY**

24.28 Section 1. **[62U.01] DEFINITIONS.**

24.29 Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this
24.30 section have the meanings given, unless otherwise specified.

24.31 Subd. 2. **Advisory committee.** "Advisory committee" means the Health Benefit Set
24.32 and Design Advisory Committee established in section 62U.055.

24.33 Subd. 3. **Clinically effective.** "Clinically effective" means that the use of a
24.34 particular health technology or service improves or prevents a decline in patient clinical

25.1 status, as measured by medical condition, survival rates, and other variables, and that the
25.2 use of the particular technology or service demonstrates a clinical or outcome advantage
25.3 over alternative technologies or services. This definition shall not be used to exclude or
25.4 deny technology or treatment necessary to preserve life on the basis of an individual's age
25.5 or expected length of life or of the individual's present or predicted disability, degree
25.6 of medical dependency, or quality of life.

25.7 Subd. 4. **Commission.** "Commission" means the Health Care Transformation
25.8 Commission established in section 62U.04.

25.9 Subd. 5. **Cost-effective.** "Cost-effective" means that the economic costs of using
25.10 a particular service, device, or health technology to achieve improvement or prevent
25.11 a decline in a patient's health outcome are justified given the comparison to both the
25.12 economic costs and the improvement in patient health outcome resulting from the use of
25.13 an alternative service, device, or technology, or from not providing the service, device,
25.14 or technology.

25.15 Subd. 6. **Health plan.** "Health plan" means a health plan as defined in section
25.16 62A.011.

25.17 Subd. 7. **Health plan company.** "Health plan company" has the meaning provided
25.18 in section 62Q.01, subdivision 4.

25.19 Subd. 8. **Health technology.** "Health technology" means medical and surgical
25.20 devices and procedures, medical equipment, and diagnostic tests.

25.21 Subd. 9. **State health care program.** "State health care program" means the
25.22 medical assistance, MinnesotaCare, and general assistance medical care programs.

25.23 Subd. 10. **Third-party administrators.** "Third-party administrators" means a
25.24 vendor of risk management services or an entity administering a self-insurance or health
25.25 insurance plan under section 60A.23.

25.26 Sec. 2. **[62U.04] HEALTH CARE TRANSFORMATION COMMISSION.**

25.27 Subdivision 1. **Creation.** The Health Care Transformation Commission is created
25.28 for the purpose of coordinating the health care transformation activities within Minnesota.

25.29 Subd. 2. **Members.** (a) The Health Care Transformation Commission shall consist
25.30 of 13 members who are appointed as follows:

25.31 (1) four nonlegislators appointed by the Subcommittee on Committees of the
25.32 Committee on Rules and Administration of the senate;

25.33 (2) four nonlegislators appointed by the speaker of the house of representatives; and

25.34 (3) five members appointed by the governor, two of whom shall be state
25.35 commissioners from the agencies listed in section 15.01.

26.1 (b) The appointed members who are not commissioners must have expertise in
26.2 health care financing, health care delivery, health care quality improvement, health
26.3 economics, actuarial science, business operations, health disparities, culturally competent
26.4 care, social services funded through medical assistance and property tax resources, or
26.5 be an informed consumer representative.

26.6 (c) If a member is no longer able or eligible to perform the required duties, a new
26.7 member shall be appointed by the entity that appointed the outgoing member.

26.8 Subd. 3. **Operations of the commission.** (a) The commission shall convene on or
26.9 before July 1, 2008, following the initial appointment of the members.

26.10 (b) The commission shall elect a chair among its members.

26.11 (c) The commission members shall not be compensated for commission activities
26.12 except for actual expenses incurred in the performance of their duties. Expenses shall be
26.13 compensated according to section 15.0575.

26.14 (d) Sixty percent of the membership of the commission constitutes a quorum.

26.15 (e) A majority of 60 percent of the membership of the commission is required for
26.16 approval or adoption of a recommendation related to performance of the duties of the
26.17 commission under subdivision 5.

26.18 Subd. 4. **Immunity of liability.** No member of the commission shall be held civilly
26.19 liable for an act or omission by that member if the act or omission was in good faith and
26.20 within the scope of the member's responsibilities under this chapter.

26.21 Subd. 5. **Responsibilities of the commission.** (a) The Health Care Transformation
26.22 Commission shall:

26.23 (1) collect data from providers on health care prices and quality, including measures
26.24 of process, outcomes, and patient satisfaction, and publish comparative price and quality
26.25 information in a manner that is easily understandable and accessible to consumers;

26.26 (2) develop a design and implementation plan for health care payment system reform
26.27 as required under sections 62U.11 and 62U.12;

26.28 (3) establish a uniform definition and methodology for calculating the relative
26.29 utilization and health care costs for providers in treating patients, including but not limited
26.30 to patients with coronary artery and heart disease, diabetes, asthma, chronic obstructive
26.31 pulmonary disease, depression, and other chronic conditions. The methodology must
26.32 include risk adjustment mechanisms that address at least the following factors:

26.33 (i) the health status of the individual in the year the individual enters the provider's
26.34 care;

26.35 (ii) a worsening of the patient's health condition that was not reasonably preventable
26.36 by action that the provider could have taken;

27.1 (iii) socioeconomic and cultural factors that bear directly on the cost of care; and
27.2 (iv) the percentage of individuals served by the provider or care system whose care
27.3 is paid for by public health insurance programs, who require highly specialized care
27.4 or who benefit from medical education;
27.5 (4) provide education, technical assistance, and materials necessary for providers to
27.6 participate in the restructured payment system;
27.7 (5) implement and administer the payment system reform;
27.8 (6) make recommendations to the governor and legislature as to additional actions
27.9 that are needed in order to successfully achieve health care transformation in Minnesota;
27.10 (7) consult and coordinate with the commissioners of health and human services,
27.11 health care providers, health plan companies, organizations that work to improve health
27.12 care quality in Minnesota, consumers, and employers;
27.13 (8) establish a Uniform Outcome Measures Working Group and make
27.14 recommendations on community benefit standards, as required under article 3, section 2;
27.15 (9) establish uniform definitions for packages of services used to provide care to
27.16 patients, including but not limited to patients with coronary artery and heart disease,
27.17 diabetes, asthma, chronic obstructive pulmonary disease, depression, and other chronic
27.18 conditions, for the purpose of establishing package pricing;
27.19 (10) submit recommendations to the legislature, by January 1, 2009, on cost-effective
27.20 methods for administering employee subsidies under section 62U.09; and
27.21 (11) carry out other duties assigned in this chapter and this article.
27.22 (b) Providers must obtain signed, written consent from patients prior to providing
27.23 patient information that identifies the patient to the commission pursuant to paragraph
27.24 (a), clause (1).
27.25 (c) The commission shall adopt rules to implement paragraph (a), clauses (1), (3),
27.26 (5), and (9).
27.27 Subd. 6. **Powers of the commission.** The commission shall have the power to:
27.28 (1) advise the commissioner of human services on federal policy changes desirable
27.29 for furthering transformation of Minnesota's health care system. The commissioner shall
27.30 also consult with the legislature on any federal changes; and
27.31 (2) contract with other organizations to carry out all or part of its responsibilities.
27.32 Subd. 7. **Standard benefit set and design.** (a) The standard health benefit set and
27.33 design must meet the requirements described in section 62U.055.
27.34 (b) Prior to recommending the standard benefit set and design, the commission shall
27.35 convene public hearings throughout the state.

28.1 Subd. 8. **Reports.** Beginning January 15, 2010, and each January 15 thereafter, the
28.2 commission shall submit an annual report to the governor and legislature on the following:
28.3 (1) the extent to which health care providers have reduced their costs and fees;
28.4 (2) the extent to which costs and cost growth are likely to be maintained or reduced
28.5 in future years;
28.6 (3) the extent to which the quality of health care services has improved;
28.7 (4) the extent to which all Minnesotans have access to quality, affordable health care;
28.8 (5) the extent to which health plan companies and third-party administrators have
28.9 reduced their costs and premiums; and
28.10 (6) recommendations on additional actions that are needed in order to successfully
28.11 achieve health care transformation in Minnesota.
28.12 Subd. 9. **Expiration.** The commission shall expire December 31, 2013.

28.13 Sec. 3. **[62U.055] STANDARD BENEFIT SET AND DESIGN.**
28.14 Subdivision 1. **Creation.** The Health Care Transformation Commission shall
28.15 convene a health benefit set and design advisory committee to make recommendations to
28.16 the legislature on a standard benefit set and design. The advisory committee shall consist
28.17 of seven members. The members shall be appointed by the commission and must have
28.18 expertise in benefit design and development, actuarial analysis, or knowledge relating to
28.19 the analysis of the cost impact of coverage of specified benefits.
28.20 Subd. 2. **Operations of the committee.** (a) The advisory committee shall convene
28.21 on or before September 1, 2008, upon the appointment of the initial committee and must
28.22 meet at least once a year, and at other times as necessary.
28.23 (b) The commission shall provide office space, equipment and supplies, and
28.24 technical support to the committee.
28.25 (c) The committee shall be governed by section 15.059, except the committee shall
28.26 not expire. Upon the expiration of the Health Care Transformation Commission, the
28.27 Health Benefit Set and Design Advisory Committee shall continue to exist under the
28.28 oversight of the commissioner of health.
28.29 Subd. 3. **Immunity of liability.** No member of the committee shall be held civilly
28.30 liable for an act or omission by that member if the act or omission was in good faith and
28.31 within the scope of the member's responsibilities under this chapter.
28.32 Subd. 4. **Duties of the committee.** (a) By January 1, 2009, the committee shall
28.33 develop and submit to the legislature a benefit set and design that provides individuals
28.34 access to a broad range of health care services, including preventive health care, dental
28.35 care, comprehensive mental health services, chemical dependency treatment, vision care,

29.1 language interpreter services, emergency transportation, and prescription drugs, without
29.2 incurring severe financial loss as a result of serious illness or injury. The benefit set
29.3 must include necessary health care services, procedures, and diagnostic tests that are
29.4 scientifically proven to be both clinically effective and cost effective. In establishing
29.5 the benefit set, the committee may contract with the Institute for Clinical Systems
29.6 Improvement (ICSI) to assemble existing scientifically based practice standards. The
29.7 committee shall consider cultural, ethnic, and religious values and beliefs to ensure that
29.8 the health care needs of all Minnesota residents will be addressed in the benefit set.

29.9 (b) The benefit set must identify and include preventive services, chronic care
29.10 coordination services, and early diagnostic tests that, if included in the benefit set, with
29.11 minimal or no cost-sharing requirements, would result in savings that are equal to or
29.12 greater than the cost of providing the services.

29.13 (c) The benefit set must include evidence-based outpatient care for asthma, heart
29.14 disease, diabetes, and depression with no cost-sharing requirements, or with minimal
29.15 cost-sharing requirements that would not impose an economic barrier to accessing the
29.16 care. The committee may consult with ICSI in identifying standards for care.

29.17 (d) The benefit design must be the only benefit plan eligible for premium subsidies
29.18 under section 62U.09. In addition, each health plan company that issues coverage in
29.19 the individual or small employer market in this state must offer at least one health plan
29.20 that complies with the benefit design in each of these two markets in which it issues
29.21 coverage. The benefit design must establish a limited number of maximum cost-sharing
29.22 variations based upon deductibles and maximum out-of-pocket costs. There must be no
29.23 maximum lifetime benefit.

29.24 Subd. 5. **Continued review.** The committee shall review the benefit set and design
29.25 on an ongoing periodic basis and shall adjust the benefit set and design as necessary, to
29.26 ensure that the benefit set and design continues to be safe, effective, and scientifically
29.27 based.

29.28 Sec. 4. **[62U.06] GOALS FOR UNIVERSAL COVERAGE.**

29.29 Subdivision 1. **Phase-in goals.** The state's phase-in goals for progress toward
29.30 universal health coverage for Minnesota residents are:

29.31 (1) 94 percent insured by end of fiscal year 2009;

29.32 (2) 96 percent insured by end of fiscal year 2011;

29.33 (3) 97 percent insured by end of fiscal year 2012; and

29.34 (4) 98 percent insured by end of fiscal year 2013 and thereafter.

30.1 Subd. 2. **Measurement of percent insured.** The determination of the percent
30.2 of Minnesota residents insured must be based on an annual survey of the Minnesota
30.3 population younger than age 65 to be conducted or contracted for by the commissioner
30.4 of health which must include questions related to the type of insurance, amount of
30.5 cost-sharing, and potential barriers to public program enrollment.

30.6 Sec. 5. **[62U.07] PROJECTED SPENDING.**

30.7 Subdivision 1. **Projected spending baseline.** (a) The commissioner of health shall
30.8 calculate the annual projected total health care spending for the state and establish a health
30.9 care spending baseline beginning for the year 2008 and for the next five years based on
30.10 the annual projected growth in spending.

30.11 (b) In establishing the health care spending baseline, the commissioner shall use
30.12 the Center of Medicare and Medicaid Services forecast for total growth in national health
30.13 care expenditures, and adjust this forecast to reflect the demographics, health status, and
30.14 other factors deemed necessary by the commissioner. The commissioner shall contract
30.15 with an actuarial consultant to make recommendations as to the adjustments needed to
30.16 specifically reflect projected spending for Minnesota residents.

30.17 (c) The commissioner may adjust the projected baseline as necessary to reflect any
30.18 updated federal projections or account for unanticipated changes in federal policy.

30.19 Subd. 2. **Actual spending.** By February 15 of each year, beginning February 15,
30.20 2010, the commissioner shall determine the actual private and public health care spending
30.21 for the calendar year preceding the current calendar year and shall determine the difference
30.22 between the projected spending as determined under subdivision 1 and the actual spending
30.23 for that year. The actual spending must be certified by an independent actuarial consultant.

30.24 Subd. 3. **Publication of spending.** By February 15 of each year, beginning February
30.25 15, 2010, the commissioner shall publish in the State Register the projected spending
30.26 baseline, including any adjustments, and the actual spending for the preceding year.

30.27 Sec. 6. **[62U.08] AFFORDABILITY STANDARD.**

30.28 Subdivision 1. **Definition of affordability.** For purposes of this section, coverage is
30.29 "affordable" if the sum of premiums, deductibles, and other out-of-pocket costs paid by an
30.30 individual or family for health coverage does not exceed the applicable percentage of the
30.31 individual or family's gross monthly income specified in subdivision 2.

30.32 Subd. 2. **Affordability standard.** The following affordability standard is
30.33 established for individuals and households with gross family incomes of 400 percent
30.34 of the federal poverty guidelines or less:

31.1 **AFFORDABILITY STANDARD**

Federal Poverty Guideline Range	Percent of Average Gross Monthly Income
0-33%	minimum
33-54%	1.1%
55-81%	1.2%
82-109%	1.6%
110-136%	2.4%
137-164%	2.9%
165-191%	3.9%
192-219%	4.6%
220-248%	5.4%
248-274%	6.0%
275-300%	6.0%
301-324%	6.5%
325-349%	7.2%
350-374%	7.8%
375-400%	8.0%

31.19 Sec. 7. **[62U.09] EMPLOYEE SUBSIDIES FOR HEALTH COVERAGE.**

31.20 Subdivision 1. **Establishment of subsidy program.** The commissioner of human
31.21 services shall establish a subsidy program for eligible employees and dependents to
31.22 provide assistance in purchasing health coverage.

31.23 Subd. 2. **Eligible employees and dependents; incomes not exceeding 300 percent**
31.24 **of the federal poverty guidelines.** In order to be eligible for a subsidy under this section,
31.25 an employee or dependent with a gross household income that does not exceed 300
31.26 percent of the federal poverty guidelines must:

31.27 (1) be covered by employer-subsidized health coverage, as defined in section
31.28 256L.07, subdivision 2, paragraph (c), that meets the benefits set and design requirements
31.29 established under section 62U.04; and

31.30 (2) meet all eligibility criteria for the MinnesotaCare program established under
31.31 chapter 256L, except for the requirements related to:

31.32 (i) no access to employer-subsidized coverage under section 256L.07, subdivision
31.33 2; and

31.34 (ii) no other health coverage under section 256L.07, subdivision 3.

31.35 Subd. 3. **Eligible employees and dependents; incomes greater than 300 percent**
31.36 **but not exceeding 400 percent of the federal poverty guidelines.** In order to be eligible
31.37 for a subsidy under this section, an employee or dependent with a gross household income

32.1 that is greater than 300 percent but does not exceed 400 percent of the federal poverty
32.2 guidelines must:
32.3 (1) be covered by health coverage that meets the benefits set and design requirements
32.4 established under section 62U.04; and
32.5 (2) meet all eligibility criteria for the MinnesotaCare program established under
32.6 chapter 256L, except for the requirements related to:
32.7 (i) no access to employer-subsidized coverage under section 256L.07, subdivision 2;
32.8 (ii) no other health coverage under section 256L.07, subdivision 3; and
32.9 (iii) gross household income under section 256L.04, subdivisions 1 and 7.
32.10 Subd. 4. **Amount of subsidy.** The subsidy must equal the amount the employee
32.11 is required to pay for health coverage for the employee and any dependents, including
32.12 premiums, deductibles, and other cost sharing, minus an amount based on the affordability
32.13 standard specified in section 62U.08. The maximum subsidy must not exceed the amount
32.14 of the subsidy that would have been provided under the MinnesotaCare program, if the
32.15 employee and any dependents were eligible for that program.
32.16 Subd. 5. **Payment of subsidy.** The commissioner shall pay the subsidy amount for
32.17 an employee and any dependents to the employee's health plan company, and this payment
32.18 shall be credited toward the employee's share of premium. Any additional amount paid
32.19 by the commissioner to the employee's health plan company that exceeds the employee's
32.20 share of premium must be credited first toward the employee deductible and then toward
32.21 any employee cost-sharing obligation.

32.22 **EFFECTIVE DATE.** This section is effective July 1, 2010.

32.23 Sec. 8. **[62U.11] PAYMENT RESTRUCTURING; PAYMENTS BASED ON**
32.24 **QUALITY OF CARE.**
32.25 Subdivision 1. **Development.** By January 15, 2009, the Health Care Transformation
32.26 Commission shall report to the legislature in the manner specified in section 3.195 on
32.27 rules to implement a payment system that links the level of payments to providers to
32.28 the quality of care. The payment system must incorporate payments to primary care
32.29 physicians, specialty care physicians, health care clinics, hospitals, and other providers
32.30 who provide services included in the evidence-based benefit set and design developed
32.31 under section 62U.04. Before January 1, 2010, the commission must adopt rules necessary
32.32 to implement this payment system.
32.33 Subd. 2. **Payment system criteria.** The payment system must meet the following
32.34 criteria:

33.1 (1) providers meeting specified targets, or who demonstrate a significant amount of
33.2 improvement over time, must be eligible for quality-based payments that are in addition to
33.3 existing payment levels;

33.4 (2) priority must be placed on measures of health care outcomes, rather than process
33.5 measures, wherever possible;

33.6 (3) quality measures for primary care providers must focus on preventive services,
33.7 coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary
33.8 disease, depression, and other conditions or procedures for which, in the determination of
33.9 the commission, improved outcomes will lead to significant cost savings;

33.10 (4) quality measures of health care outcomes must be based on medical evidence
33.11 and developed through consensus process in which providers participate;

33.12 (5) quality measures for specialty care must be designated by the commission, and
33.13 initially based on quality indicators measured and reported publicly by specialty societies;

33.14 (6) hospital payments must be adjusted for quality using existing measures where
33.15 available, which focus on health conditions or procedures for which, in the determination
33.16 of the commission, improved outcomes will lead to significant cost savings;

33.17 (7) to the greatest extent possible, the quality targets used in clause (1) must be
33.18 adjusted for variation in patient population to reduce incentives for health care providers
33.19 to locate outside of areas with high rates of poverty, a low patient base, or racial or
33.20 cultural diversity;

33.21 (8) payment methods must adjust for racial, ethnic, or language factors that affect
33.22 outcomes;

33.23 (9) quality measures cannot be different from those recommended by the uniform
33.24 outcome measures working group as approved by the Health Care Transformation
33.25 Commission; and

33.26 (10) other indicators of care quality must be incorporated where appropriate. These
33.27 indicators may include care infrastructure, collection and reporting of results, disparities
33.28 between racial and ethnic populations, and measures of overall cost of care for individuals.

33.29 Subd. 3. **Uniform measures required.** Once the payment system required by this
33.30 section is established, health plan companies shall not require providers to use and report
33.31 health plan company-specific quality and outcome measures. This shall not, however,
33.32 limit the ability of the commissioner of human services to establish by contract and
33.33 monitor, as part of its quality assurance obligations for state health care programs, outcome
33.34 and performance measures for nonmedical services and health issues likely to occur in
33.35 low-income populations or racial or cultural groups disproportionately represented in

34.1 state health care program enrollment that would likely be underrepresented when using
34.2 traditional measures that are based on longer-term enrollment.

34.3 Subd. 4. **Continued review.** The committee shall review payment restructuring
34.4 under this section on an ongoing periodic basis and shall adjust the payment system
34.5 as necessary, to ensure that the quality of care continues to be safe, effective, and
34.6 scientifically based.

34.7 Subd. 5. **Implementation.** (a) By July 1, 2010, the commissioner of human services
34.8 shall implement this payment system for all state health care program enrollees served
34.9 under fee-for-service, and shall require demonstration providers serving state health care
34.10 program enrollees to implement this payment system by July 1, 2010, for all state health
34.11 care program enrollees served under managed care and county-based purchasing.

34.12 (b) By July 1, 2010, the commissioner of employee relations shall implement this
34.13 payment system for all participants in the State Employee Group Insurance Program.

34.14 (c) By July 1, 2010, all health plan companies shall implement this payment system
34.15 for all participating providers.

34.16 Sec. 9. **[62U.12] PAYMENT RESTRUCTURING; CARE COORDINATION**
34.17 **PAYMENTS FOR HEALTH CARE HOMES.**

34.18 Subdivision 1. **Development.** The Health Care Transformation Commission,
34.19 in cooperation with the commissioners of health and human services, shall develop a
34.20 payment system that provides care coordination payments to health care providers.
34.21 In order to be eligible for a care coordination payment, a health care provider must be
34.22 certified as a health care home by the commissioners of human services and health based
34.23 on the certification standards for health care homes established under section 256B.0754.

34.24 Subd. 2. **Care coordination fee.** (a) Under the payment system, health care homes
34.25 must receive a per-person per-month care coordination fee for providing care coordination
34.26 services and utilizing care coordinators, as specified in section 256B.0752, subdivisions
34.27 3 and 7.

34.28 (b) The care coordination payment system must vary the fees paid by thresholds
34.29 of care complexity, with the highest fees being paid for care provided to individuals
34.30 requiring the most intensive care coordination, such as those with very complex health
34.31 care needs or several chronic conditions.

34.32 (c) In setting care coordination fees, group purchasers as defined in section 62J.03,
34.33 subdivision 6, shall consider the additional time and resources needed by patients with
34.34 limited English-language skills, cultural differences, or other barriers to health care.

35.1 (d) Care coordination fees may be phased in, and must be applied first to persons
35.2 who have complex or chronic health conditions.

35.3 Subd. 3. **Quality-based payments.** The quality-based payments under section
35.4 62U.11, when established, must also be included in the care coordination payment system.

35.5 Subd. 4. **Implementation.** (a) By July 1, 2009, the commissioner of human
35.6 services shall implement this payment system for all state health care program enrollees
35.7 served under fee-for-service as provided under section 256B.0753 and shall require
35.8 demonstration providers serving state health care program enrollees to implement this
35.9 payment system by July 1, 2009, for all state health care program enrollees served under
35.10 managed care and county-based purchasing.

35.11 (b) By July 1, 2009, the commissioner of employee relations shall implement this
35.12 payment system for all participants in the State Employee Group Insurance Program.

35.13 (c) By July 1, 2009, all health plan companies shall implement this payment system
35.14 for all participating providers.

35.15 Sec. 10. **[62U.13] COORDINATION WITH THE PRIVATE SECTOR.**

35.16 In developing the payment systems required under sections 62U.11 and 62U.12,
35.17 the Health Care Transformation Commission shall consult and coordinate with the
35.18 commissioners of human services and health, organizations that work to improve health
35.19 care quality in Minnesota, health care providers, health plan companies, consumers, and
35.20 employers and other payors. The commissioners shall publicize and promote the payment
35.21 systems required under sections 62U.11 and 62U.12, and shall make technical assistance
35.22 available to entities adopting the payment systems.

35.23 Sec. 11. **[62U.14] PAYMENT RESTRUCTURING: PROVIDER INNOVATION**
35.24 **TO IMPROVE COSTS AND QUALITY.**

35.25 Subdivision 1. **Development.** (a) By January 15, 2009, the Health Care
35.26 Transformation Commission shall report to the legislature recommendations for advancing
35.27 an innovative payment system for providing necessary services to patients, including but
35.28 not limited to patients with coronary artery and heart disease, diabetes, asthma, chronic
35.29 obstructive pulmonary disease, and depression.

35.30 (b) By January 1, 2010, the Health Care Transformation Commission shall report to
35.31 the legislature additional changes necessary to accomplish comprehensive payment reform
35.32 designed to support an innovative payment system to reduce costs and improve quality.

35.33 (c) By January 1, 2010, the Health Care Transformation Commission, in cooperation
35.34 with the commissioner of human services, shall develop and present to the legislature

36.1 recommendations for a comparable payment system for nonelderly and nondisabled
36.2 enrollees in the state's public health care programs and the additional changes necessary to
36.3 implement the payment system. This must include an assessment of the impact on enrollee
36.4 access to quality care and the financial status of the state's health care programs.

36.5 (d) By January 1, 2011, the Health Care Transformation Commission shall develop
36.6 rules to implement a comprehensive payment system that encourages provider innovation
36.7 to reduce costs and improve quality.

36.8 Subd. 2. **Encounter data.** (a) Beginning September 1, 2009, and every three months
36.9 thereafter, all health plan companies and third-party administrators shall submit encounter
36.10 data to the Health Care Transformation Commission. The data shall be submitted in a
36.11 form and manner specified by the commission subject to the following requirements:

36.12 (1) the data must be de-identified data as described under the Code of Federal
36.13 Regulations, title 45, section 164.514;

36.14 (2) the data for each encounter must include an identifier for the patient's health care
36.15 home if the patient has selected a health care home; and

36.16 (3) except for the identifier described in clause (2), the data must not include
36.17 information that is not included in a health care claim or equivalent encounter information
36.18 transaction that is required under section 62J.536.

36.19 (b) The commission shall only use the data submitted under paragraph (a) for the
36.20 purpose of carrying out its responsibilities in designing and implementing a payment
36.21 restructuring system. If the commission contracts with other organizations or entities to
36.22 carry out any of its duties or responsibilities described in this chapter, the contract must
36.23 require that the organization or entity maintain the data that it receives according to the
36.24 provisions of this section.

36.25 (c) Data on providers collected under this subdivision are private data on individuals
36.26 or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary
36.27 data in section 13.02, subdivision 19, summary data prepared under this section may be
36.28 derived from nonpublic data. The commission shall establish procedures and safeguards
36.29 to protect the integrity and confidentiality of any data that it maintains.

36.30 (d) The commission shall not publish analyses or reports that identify, or could
36.31 potentially identify, individual patients.

36.32 (e) The commission shall report back to providers analyses and reports that identify
36.33 specific providers. The provider shall have 21 days to review the data for accuracy.

36.34 (f) The commission shall establish an appeals process to resolve disputes from
36.35 providers regarding the accuracy of the analyses and reports.

37.1 Subd. 3. **Utilization and health care costs.** (a) The commission shall establish a
37.2 uniform definition and methodology for calculating the relative utilization and health
37.3 care costs of providers. The methodology must include risk adjustment mechanisms
37.4 that address at least the following factors:

37.5 (1) the health status of the individual in the year the individual enters the provider's
37.6 care;

37.7 (2) a worsening of the patient's health condition that was not reasonably preventable
37.8 by action that the provider could have taken;

37.9 (3) socioeconomic and cultural factors that bear directly on the cost of care; and

37.10 (4) the percentage of individuals served by the provider or care system whose care
37.11 is paid for by public health insurance programs, who require highly specialized care or
37.12 who benefit from medical education. The risk adjustment must be developed according to
37.13 generally accepted risk adjustment methodologies.

37.14 (b) Beginning April 1, 2010, the commission shall disseminate information to
37.15 providers on their utilization and cost in comparison to an appropriate peer group.

37.16 (c) The commission shall develop a system to index providers based on their
37.17 risk-adjusted resource use and on quality of care for the conditions specified in subdivision
37.18 1, paragraph (a). In developing this system, the commission shall consult and coordinate
37.19 with health care providers as defined in section 62J.03, subdivision 8, health plan
37.20 companies, and organizations that work to improve health care quality in Minnesota.

37.21 Subd. 4. **Care package pricing.** (a) The commission shall develop a standard
37.22 method and format for providers to use for submitting package prices for the conditions
37.23 specified in subdivision 1, paragraph (a). The method shall be published in the State
37.24 Register and must be made available to all providers.

37.25 (b) Beginning July 1, 2010, using the information developed in subdivision 3,
37.26 providers may submit package prices to the commission for the cost of providing
37.27 necessary services for the conditions specified in subdivision 1, paragraph (a), based on
37.28 their disclosed prices under section 62U.15 combined with their actual risk-adjusted
37.29 resource use for the most recent analytic period. The package prices submitted must
37.30 reflect the providers' commitment to manage the providers' treatment of the patients and
37.31 chronic conditions specified in subdivision 1, paragraph (a).

37.32 (c) Until January 1, 2013, no provider shall submit package prices for the
37.33 risk-adjusted cost of care for the conditions specified in subdivision 1, paragraph (a), that
37.34 represents an increase of more than the increase in the previous calendar year's Consumer
37.35 Price Index for all urban consumers plus two percentage points, or a decrease of more

38.1 than 15 percent below the providers' risk-adjusted cost of care calculated based on the
38.2 providers' average pricing levels for the previous calendar year.

38.3 (d) Beginning January 1, 2011, the commission shall annually publish the results of
38.4 the process described in paragraph (b), and shall include only providers who choose to
38.5 submit package prices. The results that are published must be on a risk-neutral basis.

38.6 Subd. 5. **Provider assistance.** The commissioner shall provide education and
38.7 technical assistance to providers on how to calculate and submit package prices for the
38.8 risk-adjusted cost of care for the conditions specified in subdivision 1, paragraph (a).

38.9 Subd. 6. **Payments.** (a) The commission shall establish a method by which
38.10 providers who have submitted package prices shall be paid for their cost of care in treating
38.11 the conditions specified in subdivision 1, paragraph (a), with periodic adjustments to the
38.12 payment they receive to reflect their actual risk-adjusted cost relative to the package price.
38.13 The commission shall report to the legislature recommendations on how to implement
38.14 the adjustments.

38.15 (b) No health care provider that submits a package price shall vary the payment
38.16 amount the provider accepts as payment in full for the package of services based on the
38.17 identity of the payer, a contractual relationship with a payer, the identity of the patient, or
38.18 whether the patient has coverage through a group purchaser. This paragraph does not apply
38.19 to services provided to patients who are enrolled in Medicare, workers' compensation,
38.20 no fault auto insurance, or a state public health care program. This paragraph does not
38.21 affect the right of a provider to provide charity care or care for a reduced price due to the
38.22 financial hardship of the patient or due to a patient being a family member.

38.23 Subd. 7. **Implementation.** By January 1, 2012, or upon legislative approval,
38.24 whichever is later:

38.25 (1) the commissioner of employee relations shall pay providers based on their
38.26 package prices for all participants in the state employee group insurance program;

38.27 (2) all political subdivisions, as defined in section 13.02, subdivision 11, that offer
38.28 health benefits to their employees must pay providers based on their package prices for all
38.29 participants, or purchase a health plan that uses this payment system;

38.30 (3) all health plan companies shall use the information and methods developed
38.31 under this section to develop at least one health plan that encourages consumers to use
38.32 high-quality, low-cost providers; and

38.33 (4) health plan companies that issue health plans in the individual market or the small
38.34 employer market must offer at least one health plan that uses the information developed
38.35 under subdivision 3 to establish financial incentives for consumers to use high-quality,
38.36 low-cost providers through enrollee cost-sharing or selective provider networks.

39.1 The legislature must approve the commissioner's plan to implement this section before
39.2 it may be implemented.

39.3 Sec. 12. **[62U.15] PROVIDER PRICE AND QUALITY DISCLOSURE.**

39.4 (a) By January 1, 2010, and annually thereafter, each physician clinic and hospital
39.5 shall establish a list of prices for each health care procedure, service, package of services,
39.6 or basket of care the provider provides and provide this information electronically to
39.7 the Health Care Transformation Commission in the form and manner specified by
39.8 the commission and at minimal cost to the provider, and the commission shall provide
39.9 this information at no cost to the public, upon request. Providers may update this list
39.10 periodically to reflect new services, supply cost changes, and other factors.

39.11 (b) The commission shall develop a plan to expand the provisions of paragraph (a) to
39.12 all health care providers by January 1, 2012. Notwithstanding this provision, health plan
39.13 companies shall submit provider price information to the commission for the purposes
39.14 of paragraph (a), for providers who do not submit prices to the commission for analysis
39.15 and provider cost performance purposes.

39.16 Sec. 13. **AMENDMENTS TO CURRENT HEALTH BENEFIT SETS.**

39.17 The commissioners of health, commerce, and employee relations shall report to the
39.18 legislature under Minnesota Statutes, section 3.195, on necessary changes to current
39.19 mandated benefit sets to align these with the standard benefit set and design developed by
39.20 the Health Care Transformation Commission established in Minnesota Statutes, section
39.21 62U.04.

39.22 Sec. 14. **RISK ADJUSTMENT.**

39.23 The Risk Adjustment Advisory Council shall review Minnesota Comprehensive
39.24 Health Association financing and whether the affordability needs of persons with health
39.25 problems can be addressed through guaranteed issue, with no premium penalty for health
39.26 history and not allowing preexisting condition limitations. This must include assessing
39.27 whether stability of the insurance market could be managed through risk sharing that
39.28 transfers funds between health plan companies. The goal is to discontinue Minnesota
39.29 Comprehensive Health Association assessment and replace it with a broader and fairer
39.30 funding mechanism, preferably one that does not involve a fee-based mechanism. The
39.31 council shall make recommendations to the legislature by November 1, 2009. The Risk
39.32 Adjustment Advisory Council shall include representatives of insurance companies, the
39.33 Minnesota Comprehensive Health Association's board of directors, safety net providers,

40.1 and consumer representatives. It shall be convened by the commissioner of commerce
40.2 with staffing from that agency and the Minnesota Department of Health.

40.3 Sec. 15. **GLOBAL MODELING OF HEALTH CARE REFORMS.**

40.4 To the extent of available appropriations, the commissioner of health shall award
40.5 a grant to the University of Minnesota School of Public Health, Health Policy and
40.6 Management Division, to develop a model that will assess the impact of proposed health
40.7 care reforms or major health care-related legislation on all sectors of the health care
40.8 system, including access to the full range of health care, public health, public and private
40.9 health insurance coverage, long-term and continuing care, programs for persons with
40.10 disabilities, social services, and other sectors related to Minnesotans' health. This model
40.11 shall be available for use within a year after the grant is awarded. The model must be:

40.12 (1) developed with safeguards to make sure that the model and its assumptions and
40.13 formulas are based on valid and objective data, research, and expert opinions;

40.14 (2) designed to enable policy makers and state agencies to enter into the model and
40.15 study each component of health care reform, including access to all aspects of health care
40.16 services, health care homes, payment reforms, populationwide prevention, health status of
40.17 Minnesotans, and incidence of chronic disease;

40.18 (3) capable of assessing the interaction of different legislative and policy changes
40.19 to determine the net effect on costs, access, and health status within sectors of the health
40.20 care system, and the net overall impact across all sectors;

40.21 (4) designed to identify risks of unpredictable or unintended consequences, cost
40.22 shifting between or within sectors of the health care system, and opportunities to make
40.23 changes in one sector that will produce a benefit to other sectors; and

40.24 (5) capable of being adjusted based on both the proposed changes and the resulting
40.25 impact in the following areas:

40.26 (i) access to all aspects of health care services;

40.27 (ii) health status of Minnesotans, including the incidence of chronic disease, health
40.28 disparities, and risk factors such as obesity and smoking;

40.29 (iii) utilization of preventive care services such as screenings, immunizations, and
40.30 physical examinations; and

40.31 (iv) costs and cost distribution, including costs to individuals and families,
40.32 businesses, and government, including for total cost of health care, health-related services,
40.33 and social services.

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

41.1 Sec. 16. **ECONOMIC ANALYSIS OF HEALTH CARE REFORM PLANS.**

41.2 (a) To the extent of available appropriations, the commissioner of health shall
41.3 award a grant to the University of Minnesota School of Public Health, Health Policy and
41.4 Management Division, to conduct a study and economic analysis of costs and benefits of
41.5 various health care reform proposals, including an analysis of the recommendations of the
41.6 Legislative Health Care Access Commission, the governor's Health Care Transformation
41.7 Task Force, and a single statewide plan.

41.8 (b) The analysis of each proposal must measure the impact on total public and
41.9 private health care spending in Minnesota that would result from each proposal, including
41.10 whether there are savings or additional costs due to:

41.11 (1) increased or reduced insurance, billing, underwriting, marketing, and other
41.12 administrative functions;

41.13 (2) timely and appropriate use of medical care;

41.14 (3) market-driven or negotiated prices on medical services and products, including
41.15 pharmaceuticals;

41.16 (4) a shortage or excess capacity of medical facilities and equipment;

41.17 (5) increased utilization, better health outcomes, increased wellness due to
41.18 prevention, early intervention, and health-promoting activities;

41.19 (6) increases or decreases in administrative expenses and health care expenses
41.20 due to payment reforms;

41.21 (7) increases or decreases in administrative expenses and health care expenses due
41.22 to coordination of care;

41.23 (8) increases or decreases in up-front and long-term utilization due to access to
41.24 comprehensive medically necessary benefits, including dental care, mental health care,
41.25 prescription drugs, and other health care; and

41.26 (9) non–health care impacts on state and local expenditures such as reduced
41.27 out-of-home placement or crime costs due to mental health or chemical dependency
41.28 coverage.

41.29 (c) The study must also analyze for each proposal the number of Minnesotans
41.30 without access to health care, including those lacking access to certain types of medical
41.31 care, such as dental care, mental health care, and prescription drugs.

41.32 (d) The study shall be completed and submitted to the legislature within one year
41.33 of final enactment.

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

41.35 Sec. 17. **APPROPRIATION.**

42.1 $15,000,000 is appropriated in fiscal year 2009 from the health care access fund to
42.2 the Health Care Transformation Commission. This is a onetime appropriation.

42.3 ## ARTICLE 5
42.4 ## PUBLIC HEALTH

42.5 Section 1. **[145.986] STATEWIDE HEALTH IMPROVEMENT PROGRAM.**
42.6 Subdivision 1. **Goals.** The initial goals of the public health improvement program
42.7 are to reduce the percentage of Minnesotans who are obese or overweight to less than 50
42.8 percent by the year 2020 and to reduce tobacco smoking by two percent annually starting
42.9 in 2011. By 2011, and considering available funding, the commissioner of health, in
42.10 consultation with the State Community Health Advisory Committee established in section
42.11 145A.10, subdivision 10, and other stakeholders, may make recommendations as to future
42.12 goals related to alcohol use and illegal drug use.
42.13 Subd. 2. **Funding local communities.** Beginning January 1, 2009, the
42.14 commissioner of health must provide funding to community health boards to convene,
42.15 coordinate, and lead locally developed programs targeted at achieving measurable health
42.16 improvement goals. Funding to each community health board will be distributed based on
42.17 a per capita formula, with a base allocation of $50,000 to each community health board
42.18 that receives funding. By January 15, 2011, the commissioner of health must recommend
42.19 whether additional funding should be distributed to community health boards based on
42.20 health disparities demonstrated in the populations served.
42.21 Subd. 3. **Outcomes.** (a) The commissioner of health must set measurable outcomes
42.22 to meet the goals specified in subdivision 1, and annually review the progress of local
42.23 communities in meeting these outcomes. The commissioner of health must provide
42.24 technical assistance and corrective action plans to ensure that local communities are
42.25 making sufficient progress.
42.26 (b) The commissioner of health must measure current public health data, using
42.27 existing measures and data collection systems when available, to determine baseline data
42.28 against which progress shall be monitored. The body mass index of individuals may not
42.29 be measured or collected for a public health study unless the individual, or the parent or
42.30 guardian if the individual is a minor, has received a Tennessen Warning and has signed a
42.31 separate informed written consent.
42.32 Subd. 4. **Evaluation.** The commissioner shall conduct an evaluation of the statewide
42.33 health improvement program using outcome measures established in subdivision 3. Local
42.34 communities shall cooperate with the commissioner in the evaluation of this program.

43.1 Sec. 2. **APPROPRIATIONS.**

43.2 $20,000,000 is appropriated from the health care access fund in fiscal year 2009 to
43.3 the commissioner of health to implement the statewide health improvement program under
43.4 Minnesota Statutes, section 145.986. Beginning January 1, 2009, the commissioner of
43.5 health shall provide funding to community health boards to implement local public health
43.6 programs. The health care access fund base for this program shall be $40,000,000 in fiscal
43.7 year 2010 and $40,000,000 in fiscal year 2011.

APPENDIX
Article locations in h3391-5

ARTICLE 1	HEALTH CARE HOMES	Page.Ln 1.21
ARTICLE 2	INCREASING ACCESS; CONTINUITY OF CARE	Page.Ln 11.1
ARTICLE 3	INSURANCE REFORM	Page.Ln 23.1
ARTICLE 4	HEALTH INSURANCE PURCHASING AND AFFORDABILITY .	Page.Ln 24.26
ARTICLE 5	PUBLIC HEALTH	Page.Ln 42.3

256L.15 PREMIUMS.

Subd. 3. **Exceptions to sliding scale.** Children in families with income at or below 150 percent of the federal poverty guidelines pay a monthly premium of $4.