MN HOUSE RESEARCH

Bill Summary

H.F. 4119

As introduced

Subject	MinnesotaCare Expansion
Authors	Mann and others
Analyst	Randall Chun
Date	March 12, 2020

Overview

This bill expands the income limit for MinnesotaCare in stages, beginning with an increase to 300 percent of FPG effective January 1, 2022, and eliminating the program income limit by 2025. The bill replaces managed care service delivery with integrated health partnerships and a primary care case management program, establishes a new premium scale based roughly on the Affordable Care Act income contribution scale, modifies provider reimbursement, establishes an advisory council, requires the commissioner of human services to submit an implementation plan to the 2021 Legislature, and makes related changes. The bill also eliminates certain exemptions from mandated health benefits. Most of the sections of the bill are effective January 1, 2022, but only if the commissioner of human services certifies to the legislature that implementation of those sections will not result in the loss of federal Basic Health Program funding.

Summary

Section	Description
1	**Compliance with other laws.** Amends § 62H.04. Strikes language that exempts joint self-insurance plans from state mandated benefit laws. Provides a contingent January 1, 2022, effective date.
2	**Compliance with other laws.** Amends § 62H.18, subd. 9. Strikes language that exempts agricultural cooperative health plans from state mandated benefit laws. Provides a contingent January 1, 2022, effective date.
3	**Restricted uses of the all-payer claims data.** Amends § 62U.04, subd. 11. Allows the commissioner of human services to use encounter data and data on contracted prices with health care providers, submitted

Section	Description

by health plan companies and third-party administrators to the commissioner of health, to set provider payment rates for MinnesotaCare.

4 **Covered health services.**

Amends § 256L.03, subd. 1. Modifies abortion coverage under MinnesotaCare, by providing that this coverage is as provided under MA. (MA generally covers abortion to prevent the death of the mother, in cases of rape or incest, and for therapeutic reasons as required by the Minnesota Supreme Court.)

5 **Families with children.**

Amends § 256L.04, subd. 1. Increases the MinnesotaCare income limit for families with children to the following percentages:

- 300 percent of FPG effective January 1, 2022;
- 400 percent of FPG effective January 1, 2024; and
- 401 percent of FPG and above effective January 1, 2025.

Effective January 1, 2022, sets the MinnesotaCare income limit for persons in farm households at 400 percent of FPG.

6 **General requirements.**

Amends § 256L.04, subd. 1c. Prohibits persons eligible for MinnesotaCare with incomes less than or equal to 200 percent of FPG from being considered qualified individuals for purposes of obtaining qualified health plan coverage through MNsure.

7 **Single adults and households with no children.**

Amends § 256L.04, subd. 7. Provides that the MinnesotaCare income limit for individuals and families with no children is increased as provided in section 256L.04, subd. 1.

8 **General requirements.**

Amends § 256L.07, subd. 1. Makes a conforming change related to the increase in the MinnesotaCare income limit.

9 **Enhanced Medicare payment rate.**

Amends § 256L.11, by adding subd. 1a. Sets MinnesotaCare provider payment rates at the enhanced Medicare rate (120 percent of the applicable Medicare payment rate), unless:

1) otherwise provided in this section;
2) the commissioner sets a different payment rate based upon an analysis of all-payer claims data; or

Section	Description

3) the commissioner negotiates a different payment rate.

10 **Service delivery under expanded MinnesotaCare program.**

Adds § 256L.122.

Subd. 1. Integrated health partnerships. Requires the commissioner to contract with integrated health partnerships (IHPs) to provide services to MinnesotaCare enrollees beginning January 1, 2022. Also requires the commissioner, to the extent feasible, to apply the RFP process and payment, quality of care, and other contract terms developed under the statute authorizing IHPs.

Subd. 2. Primary care case management. Requires the commissioner to contract with providers who are not part of an IHP, to provide covered services through the primary care case management program beginning January 1, 2022.

Subd. 3. Enrollee selection of provider. Directs the commissioner to require each enrollee to annually choose a primary care clinic or provider organization to coordinate that enrollee's care, beginning on or after January 1, 2022. Allows the commissioner to approve specialty provider to coordinate the care of enrollees with chronic or life-threatening health conditions. Allows an enrollee to change their primary care clinic or provider organization up to two times within a calendar year.

Subd. 4. Termination of contracts. Requires the commissioner to terminate managed care and county-based purchasing plan contracts effective January 1, 2022.

11 **Primary care case management and direct contracting for MinnesotaCare.**

Adds § 256L.123.

Subd. 1. Program established. Establishes the primary care case management (PCCM) program effective January 1, 2022, to achieve better health outcomes and reduce the cost of health care for the state.

Subd. 2. Payment to providers. (a) Requires the commissioner to pay providers directly to provide services to MinnesotaCare enrollees who are not receiving services through an IHP.

(b) Requires providers to bill the state directly for services they provide.

Subd. 3. Case management. (a) Requires the commissioner, in addition to paying providers under subdivision 2, to use the PCCM program to pay primary care providers for coordinating services for MinnesotaCare enrollees.

Section	Description

(b) Allows patients, under the program, to choose a primary care provider to act as the enrollee's care manager. Specifies the provider types that can provide primary care case management.

(c) States that providers who offer PCCM services shall receive a flat per-member per month fee, set to reflect the variation in time and services required for care coordination, and the complexity of a patient's health needs and socioeconomic factors that lead to health disparities.

(d) Requires the primary care provider to oversee the enrollee's health and coordinate with any other case managers of the enrollee, and ensure 24-hour access to health care, emergency treatment, and referrals.

(e) Requires the commissioner to collaborate with community health clinics and social service providers through planning and financing to provide outreach, medical care, and case management for patients who are unlikely to obtain needed care, due to mental illness, homelessness, or other circumstances.

(f) Requires the commissioner to collaborate with medical and social service providers through planning and financing to reduce hospital admissions by providing discharge planning and services, including medical respite and transitional care for patients leaving medical facilities and mental health and chemical dependency treatment programs.

Subd. 4. Duties. (a) Requires the commissioner to: (1) maintain a hotline and website to assist enrollees in locating providers; (2) provide a 24/7 nurse consultation helpline; and (3) contact enrollees based on claims data who have not had preventive visits and help them select a primary care provider.

(b) Requires the commissioner to: (1) review provider reimbursement rates to ensure reasonable and fair compensation; (2) ensure timely provider reimbursement; and (3) collaborate with providers to explore means to improve health care quality and reduce costs.

12 **Sliding fee scale; monthly individual or family income.**

Amends § 256L.15, subd. 2. A new paragraph (e) requires enrollees, effective January 1,2022, to pay premiums according the premium scale in paragraph (f). Exempts the following persons from premiums: (1) children age 20 or younger with incomes not exceeding 200 percent of FPG; and (2) individuals with household incomes below 35 percent of FPG. Requires premiums to be charged on a per-person basis, except that premiums are to be charged for a maximum of two persons within a household

Section	Description

(f) Specifies the per-person premium scale effective January 1, 2022, which roughly follows the ACA required income contribution table, except for the premium exemption for individuals with incomes below 35 percent of FPG. For incomes greater than 400 percent of FPG, requires the commissioner to determine the premium based on the current ACA required income contribution table.

13 **Employer contribution.**

Amends § 256L.15, subd. 5. Allows employers with 150 or fewer employees to pay MinnesotaCare premiums for employees enrolled in MinnesotaCare. Provides that employees are eligible for MinnesotaCare under this subdivision without regard to any program income limit, but are financially responsible for premiums based on the sliding scale.

14 **MinnesotaCare Advisory Council.**

Adds § 256L.30.

Subd. 1. Establishment and duties. Requires the commissioner to establish the MinnesotaCare Advisory Council to advise the commissioner on the transition to and ongoing administration of an expanded MinnesotaCare program. Specifies areas for recommendations. Requires the commissioner to provide the council with a written rationale, when the commissioner does not adopt or implement a recommendation of the council.

Subd. 2. Membership and governance. States that the council consists of 15 voting and 4 nonvoting members. Specifies membership and requires the commissioner to coordinate the commissioner's appointments to provide geographic, racial, and gender diversity. Specifies requirements related to governance.

Provides an immediate effective date.

15 **Transition to expanded MinnesotaCare program.**

(a) Requires the commissioner of human services to continue to administer MinnesotaCare as a Basic Health Program, and to seek any federal waivers and approvals necessary to continue to receive federal basic health program payments or to receive other federal funding for the expanded program.

(b) Requires the commissioner to present an implementation plan for the expanded MinnesotaCare program to the legislature, by December 15, 2020. Requires the plan to include:

1) recommendations for any program changes needed to receive federal funding;

Section	Description

2) a description of provider payment rates and methodologies;
3) recommendations for coordinating care delivery between the primary care case management and IHP systems;
4) recommendations for implementing section 256L.15, subdivision 5 in a manner that would allow any employee contribution towards premiums to be pre-tax;
5) recommendations for increasing MinnesotaCare provider enrollment, including an analysis of the feasibility of requiring provider participation;
6) estimates of state costs; and
7) draft legislation necessary to implement the expansion and implementation plan recommendations.

Provides an immediate effective date.

16 **Repealer.**

Subd. 1. Elimination of managed care. Repeals § 256L.12.

Subd. 2. Service delivery; competitive process. Repeals § 256L.01, subd. 7 and 256L.121, subd. 1 and 2.

Subd. 3. Payment rates. Repeals § 256L.11, subd. 1, 3, and 4.

Subd. 4. Must not have access to employer-subsidized minimum essential coverage. Repeals § 256L.07, subd. 2.

17 **Contingent effective date.**

Provides that sections 1 to 13 and 16 are effective January 1, 2022, but only if the commissioner of human services certifies to the legislature that implementation will not result in the loss of federal basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of FPG.