

156.18  
156.19**ARTICLE 4  
HEALTH CARE**

156.20 Section 1. Minnesota Statutes 2016, section 3.972, is amended by adding a subdivision  
156.21 to read:

156.22 Subd. 2b. **Audits of managed care organizations.** (a) The legislative auditor shall audit  
156.23 each managed care organization that contracts with the commissioner of human services to  
156.24 provide health care services under sections 256B.69, 256B.692, and 256L.12. The legislative  
156.25 auditor shall design the audits to determine if a managed care organization used the public  
156.26 money in compliance with federal and state laws, rules, and in accordance with provisions  
156.27 in the managed care organization's contract with the commissioner of human services. The  
156.28 legislative auditor shall determine the schedule and scope of the audit work and may contract  
156.29 with vendors to assist with the audits. The managed care organization must cooperate with  
156.30 the legislative auditor and must provide the legislative auditor with all data, documents, and  
156.31 other information, regardless of classification, that the legislative auditor requests to conduct  
156.32 an audit. The legislative auditor shall periodically report audit results and recommendations

2.33  
2.34**ARTICLE 1  
HEALTH CARE**

2.35 Section 1. Minnesota Statutes 2016, section 3.972, is amended by adding a subdivision  
2.36 to read:

2.37 Subd. 2a. **Audits of Department of Human Services.** (a) To ensure continuous  
2.38 legislative oversight and accountability, the legislative auditor shall give high priority to  
2.39 auditing the programs, services, and benefits administered by the Department of Human  
2.40 Services. The audits shall determine whether the department offered programs and provided  
2.41 services and benefits only to eligible persons and organizations, and complied with applicable  
2.42 legal requirements.

2.43 (b) The legislative auditor shall, no less than three times each year, test a representative  
2.44 sample of persons enrolled in medical assistance and MinnesotaCare to determine whether  
2.45 they are eligible to receive benefits under those programs. The legislative auditor shall report  
2.46 the results to the commissioner of human services and recommend corrective actions, which  
3.1 the commissioner must implement within 20 business days. The legislative auditor shall  
3.2 monitor the commissioner's implementation of corrective actions and periodically report  
3.3 the results to the Legislative Audit Commission and the chairs and ranking minority members  
3.4 of the legislative committees with jurisdiction over health and human services policy and  
3.5 finance. The legislative auditor's reports to the commission and the chairs and ranking  
3.6 minority members must include recommendations for any legislative actions needed to  
3.7 ensure that medical assistance and MinnesotaCare benefits are provided only to eligible  
3.8 persons.

**HOUSE ART. 1, SEC. 2 - SEE SENATE ART. 8, SEC. 2**

- 157.1 to the Legislative Audit Commission and the chairs and ranking minority members of the  
157.2 legislative committees with jurisdiction over health and human services policy and finance.
- 157.3 (b) For purposes of this subdivision, a "managed care organization" means a  
157.4 demonstration provider as defined under section 256B.69, subdivision 2.
- 157.5 Sec. 2. Minnesota Statutes 2016, section 13.69, subdivision 1, is amended to read:
- 157.6 Subdivision 1. **Classifications.** (a) The following government data of the Department  
157.7 of Public Safety are private data:
- 157.8 (1) medical data on driving instructors, licensed drivers, and applicants for parking  
157.9 certificates and special license plates issued to physically disabled persons;
- 157.10 (2) other data on holders of a disability certificate under section 169.345, except that (i)  
157.11 data that are not medical data may be released to law enforcement agencies, and (ii) data  
157.12 necessary for enforcement of sections 169.345 and 169.346 may be released to parking  
157.13 enforcement employees or parking enforcement agents of statutory or home rule charter  
157.14 cities and towns;
- 157.15 (3) Social Security numbers in driver's license and motor vehicle registration records,  
157.16 except that Social Security numbers must be provided to the Department of Revenue for  
157.17 purposes of tax administration, the Department of Labor and Industry for purposes of  
157.18 workers' compensation administration and enforcement, the Department of Human Services  
157.19 for purposes of recovery of Minnesota health care program benefits paid, and the Department  
157.20 of Natural Resources for purposes of license application administration; and
- 157.21 (4) data on persons listed as standby or temporary custodians under section 171.07,  
157.22 subdivision 11, except that the data must be released to:
- 157.23 (i) law enforcement agencies for the purpose of verifying that an individual is a designated  
157.24 caregiver; or
- 157.25 (ii) law enforcement agencies who state that the license holder is unable to communicate  
157.26 at that time and that the information is necessary for notifying the designated caregiver of  
157.27 the need to care for a child of the license holder.
- 157.28 The department may release the Social Security number only as provided in clause (3)  
157.29 and must not sell or otherwise provide individual Social Security numbers or lists of Social  
157.30 Security numbers for any other purpose.

158.1 (b) The following government data of the Department of Public Safety are confidential  
158.2 data: data concerning an individual's driving ability when that data is received from a member  
158.3 of the individual's family.

158.4 **EFFECTIVE DATE.** This section is effective July 1, 2017.

158.5 Sec. 3. **62J.815 HEALTH CARE PROVIDERS PRICE DISCLOSURES.**

158.6 (a) Each health care provider, as defined by section 62J.03, subdivision 8, except hospitals  
158.7 and outpatient surgical centers subject to the requirements of section 62J.82, shall maintain  
158.8 a list of the services or procedures that correspond with the 35 most frequent current  
158.9 procedural terminology (CPT) codes, and a list of the ten most frequent CPT codes for  
158.10 preventive services used by the provider for reimbursement purposes and the provider's  
158.11 charge for each of these services or procedures that the provider would charge to patients  
158.12 who are not covered by private or public health care coverage.

158.13 (b) This list must be updated annually and be readily available on site at no cost to the  
158.14 public. The provider must also post this information on the provider's Web site or the health  
158.15 care clinic's Web site where the provider practices.

158.16 Sec. 4. Minnesota Statutes 2016, section 62U.02, is amended to read:

158.17 **62U.02 PAYMENT RESTRUCTURING; QUALITY INCENTIVE PAYMENTS.**

158.18 Subdivision 1. **Development.** (a) The commissioner of health shall develop a standardized  
158.19 set of measures for use by health plan companies as specified in subdivision 5. As part of  
158.20 the standardized set of measures, the commissioner shall establish statewide measures by  
158.21 which to assess the quality of health care services offered by health care providers, including  
158.22 health care providers certified as health care homes under section 256B.0751. ~~Quality~~  
158.23 ~~measures must be based on medical evidence and be developed through a process in which~~  
158.24 ~~providers participate.~~ The statewide measures shall be used for the quality incentive payment  
158.25 system developed in subdivision 2 and the quality transparency requirements in subdivision  
158.26 3. The statewide measures must:

158.27 (1) for purposes of assessing the quality of care provided at physician clinics, including  
158.28 clinics certified as health care homes under section 256B.0751, be selected from the available  
158.29 measures as defined in Code of Federal Regulations, title 42, part 414 or 495, as amended,  
158.30 unless the stakeholders identified under paragraph (b) determine that a particular diagnosis,  
158.31 condition, service, or procedure is not reflected in any of the available measures in a way  
158.32 that meets identified needs;

159.1 (2) be based on medical evidence;

- 159.2 ~~(3) be developed through a process in which providers participate and consumer and~~  
159.3 ~~community input and perspectives are obtained;~~
- 159.4 ~~(4) include uniform definitions, measures, and forms for submission of data, to the~~  
159.5 ~~greatest extent possible;~~
- 159.6 ~~(2) (5) seek to avoid increasing the administrative burden on health care providers; and~~
- 159.7 ~~(3) be initially based on existing quality indicators for physician and hospital services,~~  
159.8 ~~which are measured and reported publicly by quality measurement organizations, including,~~  
159.9 ~~but not limited to, Minnesota Community Measurement and specialty societies;~~
- 159.10 ~~(4) (6) place a priority on measures of health care outcomes, rather than process measures,~~  
159.11 ~~wherever possible; and~~
- 159.12 ~~(5) incorporate measures for primary care, including preventive services, coronary artery~~  
159.13 ~~and heart disease, diabetes, asthma, depression, and other measures as determined by the~~  
159.14 ~~commissioner.~~
- 159.15 The measures may also include measures of care infrastructure and patient satisfaction.
- 159.16 (b) By June 30, 2018, the commissioner shall develop a measurement framework that  
159.17 identifies the most important elements for assessing the quality of care, articulates statewide  
159.18 quality improvement goals, ensures clinical relevance, fosters alignment with other  
159.19 measurement efforts, and defines the roles of stakeholders. By December 15, 2018, the  
159.20 commissioner shall use the framework to update the statewide measures used to assess the  
159.21 quality of health care services offered by health care providers, including health care  
159.22 providers certified as health care homes under section 256B.0751. No more than six statewide  
159.23 measures shall be required for single-specialty physician practices and no more than ten  
159.24 statewide measures shall be required for multispecialty physician practices. Measures in  
159.25 addition to the six statewide measures for single-specialty practices and the ten statewide  
159.26 measures for multispecialty practices may be included for a physician practice if derived  
159.27 from administrative claims data. Care infrastructure measures collected according to section  
159.28 62J.495 shall not be counted toward the maximum number of measures specified in this  
159.29 paragraph. The commissioner shall develop the framework in consultation with stakeholders  
159.30 that include consumer, community, and advocacy organizations representing diverse  
159.31 communities and patients; health plan companies; health care providers whose quality is  
159.32 assessed, including providers who serve primarily socioeconomically complex patient  
159.33 populations; health care purchasers; community health boards; and quality improvement  
160.1 and measurement organizations. The commissioner, in consultation with stakeholders, shall  
160.2 review the framework at least once every three years. The commissioner shall also submit  
160.3 a report to the chairs and ranking minority members of the legislative committees with

160.4 jurisdiction over health and human services policy and finance by September 30, 2018,  
160.5 summarizing the development of the measurement framework and making recommendations  
160.6 on the type and appropriate maximum number of measures in the statewide measures set  
160.7 for implementation on January 1, 2020.

160.8 ~~(b)~~ (c) Effective July 1, 2016, the commissioner shall stratify quality measures by race,  
160.9 ethnicity, preferred language, and country of origin beginning with five measures, and  
160.10 stratifying additional measures to the extent resources are available. On or after January 1,  
160.11 2018, the commissioner may require measures to be stratified by other sociodemographic  
160.12 factors or composite indices of multiple factors that according to reliable data are correlated  
160.13 with health disparities and have an impact on performance on quality or cost indicators.  
160.14 New methods of stratifying data under this paragraph must be tested and evaluated through  
160.15 pilot projects prior to adding them to the statewide system. In determining whether to add  
160.16 additional sociodemographic factors and developing the methodology to be used, the  
160.17 commissioner shall consider the reporting burden on providers and determine whether there  
160.18 are alternative sources of data that could be used. The commissioner shall ensure that  
160.19 categories and data collection methods are developed in consultation with those communities  
160.20 impacted by health disparities using culturally appropriate community engagement principles  
160.21 and methods. The commissioner shall implement this paragraph in coordination with the  
160.22 contracting entity retained under subdivision 4, in order to build upon the data stratification  
160.23 methodology that has been developed and tested by the entity. Nothing in this paragraph  
160.24 expands or changes the commissioner's authority to collect, analyze, or report health care  
160.25 data. Any data collected to implement this paragraph must be data that is available or is  
160.26 authorized to be collected under other laws. Nothing in this paragraph grants authority to  
160.27 the commissioner to collect or analyze patient-level or patient-specific data of the patient  
160.28 characteristics identified under this paragraph.

160.29 ~~(e)~~ (d) The statewide measures shall be reviewed at least annually by the commissioner.

160.30 Subd. 2. **Quality incentive payments.** (a) By July 1, 2009, the commissioner shall  
160.31 develop a system of quality incentive payments under which providers are eligible for  
160.32 quality-based payments that are in addition to existing payment levels, based upon a  
160.33 comparison of provider performance against specified targets, and improvement over time.  
160.34 The targets must be based upon and consistent with the quality measures established under  
160.35 subdivision 1.

161.1 (b) To the extent possible, the payment system must adjust for variations in patient  
161.2 population in order to reduce incentives to health care providers to avoid high-risk patients  
161.3 or populations, including those with risk factors related to race, ethnicity, language, country  
161.4 of origin, and sociodemographic factors.

161.5 (c) The requirements of section 62Q.101 do not apply under this incentive payment  
161.6 system.

161.7 Subd. 3. **Quality transparency.** (a) The commissioner shall establish standards for  
161.8 measuring health outcomes, establish a system for risk adjusting quality measures, and issue  
161.9 annual periodic public reports on trends in provider quality beginning July 1, 2010 at the  
161.10 statewide, regional, or clinic levels.

161.11 (b) Effective July 1, 2017, the risk adjustment system established under this subdivision  
161.12 shall adjust for patient characteristics identified under subdivision 1, paragraph (b) (c), that  
161.13 are correlated with health disparities and have an impact on performance on cost and quality  
161.14 measures. The risk adjustment method may consist of reporting based on an  
161.15 actual-to-expected comparison that reflects the characteristics of the patient population  
161.16 served by the clinic or hospital. The commissioner shall implement this paragraph in  
161.17 coordination with any contracting entity retained under subdivision 4.

161.18 (c) ~~By January 1, 2010,~~ Physician clinics and hospitals shall submit standardized  
161.19 electronic information on the outcomes and processes associated with patient care for the  
161.20 identified statewide measures to the commissioner or the commissioner's designee in the  
161.21 formats specified by the commissioner, which must include alternative formats for clinics  
161.22 or hospitals experiencing technological or economic barriers to submission in standardized  
161.23 electronic form. ~~In addition to measures of care processes and outcomes, the report may~~  
161.24 ~~include other measures designated by the commissioner, including, but not limited to, care~~  
161.25 ~~infrastructure and patient satisfaction. The commissioner shall ensure that any quality data~~  
161.26 ~~reporting requirements established under this subdivision are not duplicative of publicly~~  
161.27 ~~reported, communitywide quality reporting activities currently under way in Minnesota.~~  
161.28 The commissioner shall ensure that any quality data reporting requirements for physician  
161.29 clinics are aligned with the specifications and timelines for the selected measures as defined  
161.30 in subdivision 1, paragraph (a), clause (1). The commissioner may develop additional data  
161.31 on race, ethnicity, preferred language, country of origin, or other sociodemographic factors  
161.32 as identified under subdivision 1, paragraph (c), and as required for stratification or risk  
161.33 adjustment. None of the statewide measures selected shall require providers to use an external  
161.34 vendor to administer or collect data. ~~Nothing in this subdivision is intended to replace or~~  
162.1 ~~duplicate current privately supported activities related to quality measurement and reporting~~  
162.2 ~~in Minnesota.~~

162.3 Subd. 4. **Contracting.** The commissioner may contract with a private entity or consortium  
162.4 of private entities to complete the tasks in subdivisions 1 to 3. The private entity or  
162.5 consortium must be nonprofit and have governance that includes representatives from the  
162.6 following stakeholder groups: health care providers, including providers serving high  
162.7 concentrations of patients and communities impacted by health disparities; health plan  
162.8 companies; consumers, including consumers representing groups who experience health  
162.9 disparities; employers or other health care purchasers; and state government. No one  
162.10 stakeholder group shall have a majority of the votes on any issue or hold extraordinary  
162.11 powers not granted to any other governance stakeholder.

162.12 Subd. 5. **Implementation.** ~~(a) By January 1, 2010, Health plan companies shall use the~~  
162.13 ~~standardized quality set of measures established under this section and shall not require~~  
162.14 ~~providers to use and report health plan company-specific quality and outcome measures.~~

162.15 ~~(b) By July 1, 2010, the commissioner of management and budget shall implement this~~  
162.16 ~~incentive payment system for all participants in the state employee group insurance program.~~

162.17 Sec. 5. Minnesota Statutes 2016, section 62V.05, subdivision 12, is amended to read:

162.18 Subd. 12. **Reports on interagency agreements and intra-agency transfers.** The  
162.19 MNsure Board shall provide quarterly reports to the chairs and ranking minority members  
162.20 of the legislative committees with jurisdiction over health and human services policy and  
162.21 finance on:

162.22 (1) interagency agreements or service-level agreements and any renewals or extensions  
162.23 of existing interagency or service-level agreements with a state department under section  
162.24 15.01, state agency under section 15.012, or the Office of MN.IT Services, with a value of  
162.25 more than \$100,000, or related agreements with the same department or agency with a  
162.26 cumulative value of more than \$100,000; and

162.27 (2) transfers of appropriations of more than \$100,000 between accounts within or between  
162.28 agencies.

162.29 The report must include the statutory citation authorizing the agreement, transfer or dollar  
162.30 amount, purpose, and effective date of the agreement, and the duration of the agreement;  
162.31 ~~and a copy of the agreement.~~

163.1 Sec. 6. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to  
163.2 read:

163.3 Subd. 18f. **Asset verification system.** The commissioner shall implement the Asset  
163.4 Verification System (AVS) according to Public Law 110-252, title VII, section 7001(d), to  
163.5 verify assets for an individual applying for or renewing health care benefits under section  
163.6 256B.055, subdivision 7.

163.7 **EFFECTIVE DATE.** This section is effective July 1, 2017.

163.8 Sec. 7. Minnesota Statutes 2016, section 256.01, subdivision 41, is amended to read:

163.9 Subd. 41. **Reports on interagency agreements and intra-agency transfers.** The  
163.10 commissioner of human services shall provide quarterly reports to the chairs and ranking

163.11 minority members of the legislative committees with jurisdiction over health and human  
 163.12 services policy and finance on:

163.13 (1) interagency agreements or service-level agreements and any renewals or extensions  
 163.14 of existing interagency or service-level agreements with a state department under section  
 163.15 15.01, state agency under section 15.012, or the Office of MN.IT Services, with a value of  
 163.16 more than \$100,000, or related agreements with the same department or agency with a  
 163.17 cumulative value of more than \$100,000; and

163.18 (2) transfers of appropriations of more than \$100,000 between accounts within or between  
 163.19 agencies.

163.20 The report must include the statutory citation authorizing the agreement, transfer or dollar  
 163.21 amount, purpose, and effective date of the agreement, and the duration of the agreement;  
 163.22 and a copy of the agreement.

163.23 Sec. 8. Minnesota Statutes 2016, section 256.969, subdivision 2b, is amended to read:

4.20 Sec. 3. Minnesota Statutes 2016, section 256.9686, subdivision 8, is amended to read:

4.21 Subd. 8. **Rate year.** "Rate year" means a calendar year from January 1 to December 31.  
 4.22 Effective with the 2012 base year, rate year means a state fiscal year from July 1 to June  
 4.23 30.

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

4.25 Sec. 4. Minnesota Statutes 2016, section 256.969, subdivision 1, is amended to read:

4.26 Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in  
 4.27 the Centers for Medicare and Medicaid Services Inpatient Hospital Market Basket. The  
 4.28 commissioner shall use the indices as forecasted for the midpoint of the prior rate year to  
 4.29 the midpoint of the current rate year.

5.1 (b) Except as authorized under this section, for fiscal years beginning on or after July  
 5.2 1, 1993, the commissioner of human services shall not provide automatic annual inflation  
 5.3 adjustments for hospital payment rates under medical assistance.

5.4 **EFFECTIVE DATE.** This section is effective July 1, 2017.

5.5 Sec. 5. Minnesota Statutes 2016, section 256.969, subdivision 2b, is amended to read:



163.24 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November  
163.25 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according  
163.26 to the following:

163.27 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based  
163.28 methodology;

163.29 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology  
163.30 under subdivision 25;

164.1 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation  
164.2 distinct parts as defined by Medicare shall be paid according to the methodology under  
164.3 subdivision 12; and

164.4 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

164.5 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not  
164.6 be rebased, except that a Minnesota long-term hospital shall be rebased effective January  
164.7 1, 2011, based on its most recent Medicare cost report ending on or before September 1,  
164.8 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on  
164.9 December 31, 2010. For rate setting periods after November 1, 2014, in which the base  
164.10 years are updated, a Minnesota long-term hospital's base year shall remain within the same  
164.11 period as other hospitals.

164.12 (c) Effective for discharges occurring on and after November 1, 2014, payment rates  
164.13 for hospital inpatient services provided by hospitals located in Minnesota or the local trade  
164.14 area, except for the hospitals paid under the methodologies described in paragraph (a),  
164.15 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a  
164.16 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall  
164.17 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring  
164.18 that the total aggregate payments under the rebased system are equal to the total aggregate  
164.19 payments that were made for the same number and types of services in the base year. Separate  
164.20 budget neutrality calculations shall be determined for payments made to critical access  
164.21 hospitals and payments made to hospitals paid under the DRG system. Only the rate increases  
164.22 or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during  
164.23 the entire base period shall be incorporated into the budget neutrality calculation.

164.24 (d) For discharges occurring on or after November 1, 2014, through the next rebasing  
164.25 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph  
164.26 (a), clause (4), shall include adjustments to the projected rates that result in no greater than  
164.27 a five percent increase or decrease from the base year payments for any hospital. Any

5.6 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November  
5.7 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according  
5.8 to the following:

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5.10 methodology;

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5.12 under subdivision 25;

5.13 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation  
5.14 distinct parts as defined by Medicare shall be paid according to the methodology under  
5.15 subdivision 12; and

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5.18 be rebased, except that a Minnesota long-term hospital shall be rebased effective January  
5.19 1, 2011, based on its most recent Medicare cost report ending on or before September 1,  
5.20 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on  
5.21 December 31, 2010. For rate setting periods after November 1, 2014, in which the base  
5.22 years are updated, a Minnesota long-term hospital's base year shall remain within the same  
5.23 period as other hospitals.

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5.28 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall  
5.29 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring  
5.30 that the total aggregate payments under the rebased system are equal to the total aggregate  
5.31 payments that were made for the same number and types of services in the base year. Separate  
5.32 budget neutrality calculations shall be determined for payments made to critical access  
5.33 hospitals and payments made to hospitals paid under the DRG system. Only the rate increases  
6.1 or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during  
6.2 the entire base period shall be incorporated into the budget neutrality calculation.

6.3 (d) For discharges occurring on or after November 1, 2014, through the next rebasing  
6.4 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph  
6.5 (a), clause (4), shall include adjustments to the projected rates that result in no greater than  
6.6 a five percent increase or decrease from the base year payments for any hospital. Any

164.28 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)  
164.29 shall maintain budget neutrality as described in paragraph (c).

164.30 (e) For discharges occurring on or after November 1, 2014, through the next rebasing  
164.31 ~~that occurs~~ the commissioner may make additional adjustments to the rebased rates, and  
164.32 when evaluating whether additional adjustments should be made, the commissioner shall  
164.33 consider the impact of the rates on the following:

164.34 (1) pediatric services;

165.1 (2) behavioral health services;

165.2 (3) trauma services as defined by the National Uniform Billing Committee;

165.3 (4) transplant services;

165.4 (5) obstetric services, newborn services, and behavioral health services provided by  
165.5 hospitals outside the seven-county metropolitan area;

165.6 (6) outlier admissions;

165.7 (7) low-volume providers; and

165.8 (8) services provided by small rural hospitals that are not critical access hospitals.

165.9 (f) Hospital payment rates established under paragraph (c) must incorporate the following:

165.10 (1) for hospitals paid under the DRG methodology, the base year payment rate per  
165.11 admission is standardized by the applicable Medicare wage index and adjusted by the  
165.12 hospital's disproportionate population adjustment;

165.13 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,  
165.14 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on  
165.15 October 31, 2014;

165.16 (3) the cost and charge data used to establish hospital payment rates must only reflect  
165.17 inpatient services covered by medical assistance; and

165.18 (4) in determining hospital payment rates for discharges occurring on or after the rate  
165.19 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per

6.7 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)  
6.8 shall maintain budget neutrality as described in paragraph (c).

6.9 (e) For discharges occurring on or after November 1, 2014, through the next ~~two~~ rebasing  
6.10 ~~that occurs~~ periods the commissioner may make additional adjustments to the rebased rates,  
6.11 and when evaluating whether additional adjustments should be made, the commissioner  
6.12 shall consider the impact of the rates on the following:

6.13 (1) pediatric services;

6.14 (2) behavioral health services;

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6.24 admission is standardized by the applicable Medicare wage index and adjusted by the  
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6.27 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on  
6.28 October 31, 2014;

6.29 (3) the cost and charge data used to establish hospital payment rates must only reflect  
6.30 inpatient services covered by medical assistance; and

7.1 (4) in determining hospital payment rates for discharges occurring on or after the rate  
7.2 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per  
7.3 discharge shall be based on the cost-finding methods and allowable costs of the Medicare

165.20 discharge shall be based on the cost-finding methods and allowable costs of the Medicare  
165.21 program in effect during the base year or years.

165.22 (g) The commissioner shall validate the rates effective November 1, 2014, by applying  
165.23 the rates established under paragraph (c), and any adjustments made to the rates under  
165.24 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the  
165.25 total aggregate payments for the same number and types of services under the rebased rates  
165.26 are equal to the total aggregate payments made during calendar year 2013.

165.27 (h) Effective for discharges occurring on or after July 1, ~~2017~~ 2021, and every two years  
165.28 thereafter, payment rates under this section shall be rebased to reflect only those changes  
165.29 in hospital costs between the existing base year and the next base year. The commissioner  
165.30 shall establish the base year for each rebasing period considering the most recent year for  
165.31 which filed Medicare cost reports are available. The estimated change in the average payment  
165.32 per hospital discharge resulting from a scheduled rebasing must be calculated and made  
166.1 available to the legislature by January 15 of each year in which rebasing is scheduled to  
166.2 occur, and must include by hospital the differential in payment rates compared to the  
166.3 individual hospital's costs.

166.4 (i) Effective for discharges occurring on or after July 1, 2015, payment rates for critical  
166.5 access hospitals located in Minnesota or the local trade area shall be determined using a  
166.6 new cost-based methodology. The commissioner shall establish within the methodology  
166.7 tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for  
166.8 hospitals under this paragraph shall be set at a level that does not exceed the total cost for  
166.9 critical access hospitals as reflected in base year cost reports. Until the next rebasing that  
166.10 occurs, the new methodology shall result in no greater than a five percent decrease from  
166.11 the base year payments for any hospital, except a hospital that had payments that were  
166.12 greater than 100 percent of the hospital's costs in the base year shall have their rate set equal  
166.13 to 100 percent of costs in the base year. The rates paid for discharges on and after July 1,  
166.14 2016, covered under this paragraph shall be increased by the inflation factor in subdivision  
166.15 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to  
166.16 actual incurred costs. Hospitals shall be assigned a payment tier based on the following  
166.17 criteria:

166.18 (1) hospitals that had payments at or below 80 percent of their costs in the base year  
166.19 shall have a rate set that equals 85 percent of their base year costs;

7.4 program in effect during the base year or years. In determining hospital payment rates for  
7.5 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding  
7.6 methods and allowable costs of the Medicare program in effect during the base year or  
7.7 years.

7.8 (g) The commissioner shall validate the rates effective November 1, 2014, by applying  
7.9 the rates established under paragraph (c), and any adjustments made to the rates under  
7.10 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the  
7.11 total aggregate payments for the same number and types of services under the rebased rates  
7.12 are equal to the total aggregate payments made during calendar year 2013.

7.13 (h) Effective for discharges occurring on or after July 1, 2017, and every two years  
7.14 thereafter, payment rates under this section shall be rebased to reflect only those changes  
7.15 in hospital costs between the existing base year and the next base year. Changes in costs  
7.16 between base years shall be measured using the lower of the hospital cost index defined in  
7.17 subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per  
7.18 claim. The commissioner shall establish the base year for each rebasing period considering  
7.19 the most recent year for which filed Medicare cost reports are available. The estimated  
7.20 change in the average payment per hospital discharge resulting from a scheduled rebasing  
7.21 must be calculated and made available to the legislature by January 15 of each year in which  
7.22 rebasing is scheduled to occur, and must include by hospital the differential in payment  
7.23 rates compared to the individual hospital's costs.

7.24 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates  
7.25 for critical access hospitals located in Minnesota or the local trade area shall be determined  
7.26 using a new cost-based methodology. The commissioner shall establish within the  
7.27 methodology tiers of payment designed to promote efficiency and cost-effectiveness.  
7.28 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed  
7.29 the total cost for critical access hospitals as reflected in base year cost reports. Until the  
7.30 next rebasing that occurs, the new methodology shall result in no greater than a five percent  
7.31 decrease from the base year payments for any hospital, except a hospital that had payments  
7.32 that were greater than 100 percent of the hospital's costs in the base year shall have their  
7.33 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and  
7.34 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor  
7.35 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not  
8.1 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the  
8.2 following criteria:

8.3 (1) hospitals that had payments at or below 80 percent of their costs in the base year  
8.4 shall have a rate set that equals 85 percent of their base year costs;

166.20 (2) hospitals that had payments that were above 80 percent, up to and including 90  
 166.21 percent of their costs in the base year shall have a rate set that equals 95 percent of their  
 166.22 base year costs; and

166.23 (3) hospitals that had payments that were above 90 percent of their costs in the base year  
 166.24 shall have a rate set that equals 100 percent of their base year costs.

166.25 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals  
 166.26 to coincide with the next rebasing under paragraph (h). The factors used to develop the new  
 166.27 methodology may include, but are not limited to:

166.28 (1) the ratio between the hospital's costs for treating medical assistance patients and the  
 166.29 hospital's charges to the medical assistance program;

166.30 (2) the ratio between the hospital's costs for treating medical assistance patients and the  
 166.31 hospital's payments received from the medical assistance program for the care of medical  
 166.32 assistance patients;

167.1 (3) the ratio between the hospital's charges to the medical assistance program and the  
 167.2 hospital's payments received from the medical assistance program for the care of medical  
 167.3 assistance patients;

167.4 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

167.5 (5) the proportion of that hospital's costs that are administrative and trends in  
 167.6 administrative costs; and

167.7 (6) geographic location.

167.8 Sec. 9. Minnesota Statutes 2016, section 256.969, is amended by adding a subdivision to  
 167.9 read:

167.10 Subd. 2e. **Alternate inpatient payment rate.** (a) If the days, costs, and revenues  
 167.11 associated with patients who are eligible for medical assistance and also have private health  
 167.12 insurance are required to be included in the calculation of the hospital-specific  
 167.13 disproportionate share hospital payment limit for a rate year, then the commissioner, effective  
 167.14 retroactively from rate years beginning on or after January 1, 2015, shall compute an alternate  
 167.15 inpatient payment rate for a Minnesota hospital that is designated as a children's hospital  
 167.16 and enumerated as such by Medicare. The commissioner shall reimburse the hospital for a

8.5 (2) hospitals that had payments that were above 80 percent, up to and including 90  
 8.6 percent of their costs in the base year shall have a rate set that equals 95 percent of their  
 8.7 base year costs; and

8.8 (3) hospitals that had payments that were above 90 percent of their costs in the base year  
 8.9 shall have a rate set that equals 100 percent of their base year costs.

8.10 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals  
 8.11 to coincide with the next rebasing under paragraph (h). The factors used to develop the new  
 8.12 methodology may include, but are not limited to:

8.13 (1) the ratio between the hospital's costs for treating medical assistance patients and the  
 8.14 hospital's charges to the medical assistance program;

8.15 (2) the ratio between the hospital's costs for treating medical assistance patients and the  
 8.16 hospital's payments received from the medical assistance program for the care of medical  
 8.17 assistance patients;

8.18 (3) the ratio between the hospital's charges to the medical assistance program and the  
 8.19 hospital's payments received from the medical assistance program for the care of medical  
 8.20 assistance patients;

8.21 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

8.22 (5) the proportion of that hospital's costs that are administrative and trends in  
 8.23 administrative costs; and

8.24 (6) geographic location.

8.25 **EFFECTIVE DATE. This section is effective July 1, 2017.**

8.26 Sec. 6. Minnesota Statutes 2016, section 256.969, is amended by adding a subdivision to  
 8.27 read:

8.28 Subd. 2e. **Alternate inpatient payment rate.** (a) If the days, costs, and revenues  
 8.29 associated with patients who are eligible for medical assistance and also have private health  
 8.30 insurance are required to be included in the calculation of the hospital-specific  
 8.31 disproportionate share hospital payment limit for a rate year, then the commissioner, effective  
 9.1 retroactively to rate years beginning on or after January 1, 2015, shall compute an alternate  
 9.2 inpatient payment rate for a Minnesota hospital that is designated as a children's hospital  
 9.3 and enumerated as such by Medicare. The commissioner shall reimburse the hospital for a

167.17 rate year at the higher of the amount calculated under the alternate payment rate or the  
 167.18 amount calculated under subdivision 9.

167.19 (b) The alternate payment rate must meet the criteria in clauses (1) to (4):

167.20 (1) the alternate payment rate shall be structured to target a total aggregate reimbursement  
 167.21 amount equal to two percent less than each children's hospital's cost coverage percentage  
 167.22 in the applicable base year for providing fee-for-service inpatient services under this section  
 167.23 to patients enrolled in medical assistance;

167.24 (2) costs shall be determined using the most recently available medical assistance cost  
 167.25 report provided under subdivision 4b, paragraph (a), clause (3), for the applicable base year.  
 167.26 Costs shall be determined using standard Medicare cost finding and cost allocation methods  
 167.27 and applied in the same manner as the costs were in the rebasing for the applicable base  
 167.28 year. If the medical assistance cost report is not available, costs shall be determined in the  
 167.29 interim using the Medicare cost report;

167.30 (3) in any rate year in which payment to a hospital is made using the alternate payment  
 167.31 rate, no payments shall be made to the hospital under subdivision 9; and

168.1 (4) if the alternate payment amount increases payments at a rate that is higher than the  
 168.2 inflation factor applied over the rebasing period, the commissioner shall take this into  
 168.3 consideration when setting payment rates at the next rebasing.

9.4 rate year at the higher of the amount calculated under the alternate payment rate or the  
 9.5 amount calculated under subdivision 9.

9.6 (b) The alternate payment rate must meet the criteria in clauses (1) to (4):

9.7 (1) the alternate payment rate shall be structured to target a total aggregate reimbursement  
 9.8 amount equal to two percent less than each children's hospital's cost coverage percentage  
 9.9 in the applicable base year for providing fee-for-service inpatient services under this section  
 9.10 to patients enrolled in medical assistance;

9.11 (2) costs shall be determined using the most recently available medical assistance cost  
 9.12 report provided under subdivision 4b, paragraph (a), clause (3), for the applicable base year.  
 9.13 Costs shall be determined using standard Medicare cost finding and cost allocation methods  
 9.14 and applied in the same manner as the costs were in the rebasing for the applicable base  
 9.15 year. If the medical assistance cost report is not available, costs shall be determined in the  
 9.16 interim using the Medicare Cost Report;

9.17 (3) in any rate year in which payment to a hospital is made using the alternate payment  
 9.18 rate, no payments shall be made to the hospital under subdivision 9; and

9.19 (4) if the alternate payment amount increases payments at a rate that is higher than the  
 9.20 inflation factor applied over the rebasing period, the commissioner shall take this into  
 9.21 consideration when setting payment rates at the next rebasing.

9.22 Sec. 7. Minnesota Statutes 2016, section 256.969, subdivision 3a, is amended to read:

9.23 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program  
 9.24 must not be submitted until the recipient is discharged. However, the commissioner shall  
 9.25 establish monthly interim payments for inpatient hospitals that have individual patient  
 9.26 lengths of stay over 30 days regardless of diagnostic category. Except as provided in section  
 9.27 256.9693, medical assistance reimbursement for treatment of mental illness shall be  
 9.28 reimbursed based on diagnostic classifications. Individual hospital payments established  
 9.29 under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party  
 9.30 and recipient liability, for discharges occurring during the rate year shall not exceed, in  
 9.31 aggregate, the charges for the medical assistance covered inpatient services paid for the  
 9.32 same period of time to the hospital. Services that have rates established under subdivision  
 9.33 ~~11~~ or 12, must be limited separately from other services. After consulting with the affected  
 10.1 hospitals, the commissioner may consider related hospitals one entity and may merge the  
 10.2 payment rates while maintaining separate provider numbers. The operating and property  
 10.3 base rates per admission or per day shall be derived from the best Medicare and claims data  
 10.4 available when rates are established. The commissioner shall determine the best Medicare  
 10.5 and claims data, taking into consideration variables of recency of the data, audit disposition,  
 10.6 settlement status, and the ability to set rates in a timely manner. The commissioner shall

10.7 notify hospitals of payment rates 30 days prior to implementation. The rate setting data  
10.8 must reflect the admissions data used to establish relative values. The commissioner may  
10.9 adjust base year cost, relative value, and case mix index data to exclude the costs of services  
10.10 that have been discontinued by the October 1 of the year preceding the rate year or that are  
10.11 paid separately from inpatient services. Inpatient stays that encompass portions of two or  
10.12 more rate years shall have payments established based on payment rates in effect at the time  
10.13 of admission unless the date of admission preceded the rate year in effect by six months or  
10.14 more. In this case, operating payment rates for services rendered during the rate year in  
10.15 effect and established based on the date of admission shall be adjusted to the rate year in  
10.16 effect by the hospital cost index.

10.17 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment,  
10.18 before third-party liability and spenddown, made to hospitals for inpatient services is reduced  
10.19 by .5 percent from the current statutory rates.

10.20 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service  
10.21 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before  
10.22 third-party liability and spenddown, is reduced five percent from the current statutory rates.  
10.23 Mental health services within diagnosis related groups 424 to 432 or corresponding  
10.24 APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph.

10.25 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for  
10.26 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for  
10.27 inpatient services before third-party liability and spenddown, is reduced 6.0 percent from  
10.28 the current statutory rates. Mental health services within diagnosis related groups 424 to  
10.29 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded  
10.30 from this paragraph. Payments made to managed care plans shall be reduced for services  
10.31 provided on or after January 1, 2006, to reflect this reduction.

10.32 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for  
10.33 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made  
10.34 to hospitals for inpatient services before third-party liability and spenddown, is reduced  
10.35 3.46 percent from the current statutory rates. Mental health services with diagnosis related  
11.1 groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision  
11.2 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced  
11.3 for services provided on or after January 1, 2009, through June 30, 2009, to reflect this  
11.4 reduction.

11.5 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for  
11.6 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made  
11.7 to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9  
11.8 percent from the current statutory rates. Mental health services with diagnosis related groups  
11.9 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are

11.10 excluded from this paragraph. Payments made to managed care plans shall be reduced for  
 11.11 services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

11.12 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for  
 11.13 fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient  
 11.14 services before third-party liability and spenddown, is reduced 1.79 percent from the current  
 11.15 statutory rates. Mental health services with diagnosis related groups 424 to 432 or  
 11.16 corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from  
 11.17 this paragraph. Payments made to managed care plans shall be reduced for services provided  
 11.18 on or after July 1, 2011, to reflect this reduction.

11.19 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment  
 11.20 for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for  
 11.21 inpatient services before third-party liability and spenddown, is reduced one percent from  
 11.22 the current statutory rates. Facilities defined under subdivision 16 are excluded from this  
 11.23 paragraph. Payments made to managed care plans shall be reduced for services provided  
 11.24 on or after October 1, 2009, to reflect this reduction.

11.25 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment  
 11.26 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for  
 11.27 inpatient services before third-party liability and spenddown, is reduced 1.96 percent from  
 11.28 the current statutory rates. Facilities defined under subdivision 16 are excluded from this  
 11.29 paragraph. Payments made to managed care plans shall be reduced for services provided  
 11.30 on or after January 1, 2011, to reflect this reduction.

11.31 (j) Effective for discharges on and after November 1, 2014, from hospitals paid under  
 11.32 subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision  
 11.33 must be incorporated into the rebased rates established under subdivision 2b, paragraph (c),  
 11.34 and must not be applied to each claim.

12.1 (k) Effective for discharges on and after July 1, 2015, from hospitals paid under  
 12.2 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision  
 12.3 must be incorporated into the rates and must not be applied to each claim.

12.4 (l) Effective for discharges on and after July 1, 2017, from hospitals paid under  
 12.5 subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be  
 12.6 incorporated into the rates and must not be applied to each claim.

12.7 **EFFECTIVE DATE.** This section is effective July 1, 2017.

168.4 Sec. 10. Minnesota Statutes 2016, section 256.969, subdivision 4b, is amended to read:

12.8 Sec. 8. Minnesota Statutes 2016, section 256.969, subdivision 4b, is amended to read:

168.5 Subd. 4b. **Medical assistance cost reports for services.** (a) A hospital that meets one  
 168.6 of the following criteria must annually submit to the commissioner medical assistance cost  
 168.7 reports within six months of the end of the hospital's fiscal year:

168.8 (1) a hospital designated as a critical access hospital that receives medical assistance  
 168.9 payments; ~~or~~

168.10 (2) a Minnesota hospital or out-of-state hospital located within a Minnesota local trade  
 168.11 area that receives a disproportionate population adjustment under subdivision 9; or

168.12 (3) a Minnesota hospital that is designated as a children's hospital and enumerated as  
 168.13 such by Medicare.

168.14 For purposes of this subdivision, local trade area has the meaning given in subdivision  
 168.15 17.

168.16 (b) The commissioner shall suspend payments to any hospital that fails to submit a report  
 168.17 required under this subdivision. Payments must remain suspended until the report has been  
 168.18 filed with and accepted by the commissioner.

168.19 **EFFECTIVE DATE.** This section is effective July 1, 2017.

12.9 Subd. 4b. **Medical assistance cost reports for services.** (a) A hospital that meets one  
 12.10 of the following criteria must annually submit to the commissioner medical assistance cost  
 12.11 reports within six months of the end of the hospital's fiscal year:

12.12 (1) a hospital designated as a critical access hospital that receives medical assistance  
 12.13 payments; ~~or~~

12.14 (2) a Minnesota hospital or out-of-state hospital located within a Minnesota local trade  
 12.15 area that receives a disproportionate population adjustment under subdivision 9; or

12.16 (3) a Minnesota hospital that is designated as a children's hospital and enumerated as  
 12.17 such by Medicare.

12.18 For purposes of this subdivision, local trade area has the meaning given in subdivision  
 12.19 17.

12.20 (b) The commissioner shall suspend payments to any hospital that fails to submit a report  
 12.21 required under this subdivision. Payments must remain suspended until the report has been  
 12.22 filed with and accepted by the commissioner.

12.23 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2015.

12.24 Sec. 9. Minnesota Statutes 2016, section 256.969, subdivision 8, is amended to read:

12.25 Subd. 8. **Unusual length of stay experience.** (a) The commissioner shall establish day  
 12.26 outlier thresholds for each diagnostic category established under subdivision 2 at two standard  
 12.27 deviations beyond the mean length of stay. Payment for the days beyond the outlier threshold  
 12.28 shall be in addition to the operating and property payment rates per admission established  
 12.29 under subdivisions 2 and 2b. Payment for outliers shall be at 70 percent of the allowable  
 12.30 operating cost, after adjustment by the case mix index, hospital cost index, relative values  
 12.31 and the disproportionate population adjustment. The outlier threshold for neonatal and burn  
 13.1 diagnostic categories shall be established at one standard deviation beyond the mean length  
 13.2 of stay, and payment shall be at 90 percent of allowable operating cost calculated in the  
 13.3 same manner as other outliers. A hospital may choose an alternative to the 70 percent outlier  
 13.4 payment that is at a minimum of 60 percent and a maximum of 80 percent if the  
 13.5 commissioner is notified in writing of the request by October 1 of the year preceding the  
 13.6 rate year. The chosen percentage applies to all diagnostic categories except burns and  
 13.7 neonates. The percentage of allowable cost that is unrecognized by the outlier payment shall  
 13.8 be added back to the base year operating payment rate per admission.



- 13.9 (b) Effective for admissions and transfers occurring on and after November 1, 2014, the  
13.10 commissioner shall establish payment rates for outlier payments that are based on Medicare  
13.11 methodologies.
- 13.12 **EFFECTIVE DATE.** This section is effective July 1, 2017.
- 13.13 Sec. 10. Minnesota Statutes 2016, section 256.969, subdivision 8c, is amended to read:
- 13.14 Subd. 8c. **Hospital residents.** (a) For discharges occurring on or after November 1,  
13.15 2014, payments for hospital residents shall be made as follows:
- 13.16 (1) payments for the first 180 days of inpatient care shall be the APR-DRG system plus  
13.17 any outliers; and
- 13.18 (2) payment for all medically necessary patient care subsequent to the first 180 days  
13.19 shall be reimbursed at a rate computed by multiplying the statewide average cost-to-charge  
13.20 ratio by the usual and customary charges.
- 13.21 (b) For discharges occurring on or after July 1, 2017, payment for hospital residents  
13.22 shall be equal to the payments under subdivision 8, paragraph (b).
- 13.23 **EFFECTIVE DATE.** This section is effective July 1, 2017.
- 13.24 Sec. 11. Minnesota Statutes 2016, section 256.969, subdivision 9, is amended to read:
- 13.25 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions  
13.26 occurring on or after July 1, 1993, the medical assistance disproportionate population  
13.27 adjustment shall comply with federal law and shall be paid to a hospital, excluding regional  
13.28 treatment centers and facilities of the federal Indian Health Service, with a medical assistance  
13.29 inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined  
13.30 as follows:
- 14.1 (1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic  
14.2 mean for all hospitals excluding regional treatment centers and facilities of the federal Indian  
14.3 Health Service but less than or equal to one standard deviation above the mean, the  
14.4 adjustment must be determined by multiplying the total of the operating and property  
14.5 payment rates by the difference between the hospital's actual medical assistance inpatient  
14.6 utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers  
14.7 and facilities of the federal Indian Health Service; and
- 14.8 (2) for a hospital with a medical assistance inpatient utilization rate above one standard  
14.9 deviation above the mean, the adjustment must be determined by multiplying the adjustment

- 14.10 that would be determined under clause (1) for that hospital by 1.1. The commissioner shall  
14.11 report annually on the number of hospitals likely to receive the adjustment authorized by  
14.12 this paragraph. The commissioner shall specifically report on the adjustments received by  
14.13 public hospitals and public hospital corporations located in cities of the first class.
- 14.14 (b) Certified public expenditures made by Hennepin County Medical Center shall be  
14.15 considered Medicaid disproportionate share hospital payments. Hennepin County and  
14.16 Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning  
14.17 July 1, 2005, or another date specified by the commissioner, that may qualify for  
14.18 reimbursement under federal law. Based on these reports, the commissioner shall apply for  
14.19 federal matching funds.
- 14.20 (c) Upon federal approval of the related state plan amendment, paragraph (b) is effective  
14.21 retroactively from July 1, 2005, or the earliest effective date approved by the Centers for  
14.22 Medicare and Medicaid Services.
- 14.23 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid  
14.24 in accordance with a new methodology using 2012 as the base year. Annual payments made  
14.25 under this paragraph shall equal the total amount of payments made for 2012. A licensed  
14.26 children's hospital shall receive only a single DSH factor for children's hospitals. Other  
14.27 DSH factors may be combined to arrive at a single factor for each hospital that is eligible  
14.28 for DSH payments. The new methodology shall make payments only to hospitals located  
14.29 in Minnesota and include the following factors:
- 14.30 (1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the  
14.31 base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000  
14.32 fee-for-service discharges in the base year shall receive a factor of 0.7880;
- 15.1 (2) a hospital that has in effect for the initial rate year a contract with the commissioner  
15.2 to provide extended psychiatric inpatient services under section 256.9693 shall receive a  
15.3 factor of 0.0160;
- 15.4 (3) a hospital that has received payment from the fee-for-service program for at least 20  
15.5 transplant services in the base year shall receive a factor of 0.0435;
- 15.6 (4) a hospital that has a medical assistance utilization rate in the base year between 20  
15.7 percent up to one standard deviation above the statewide mean utilization rate shall receive  
15.8 a factor of 0.0468;
- 15.9 (5) a hospital that has a medical assistance utilization rate in the base year that is at least  
15.10 one standard deviation above the statewide mean utilization rate but is less than three standard  
15.11 deviations above the mean shall receive a factor of 0.2300; and

15.12 (6) a hospital that has a medical assistance utilization rate in the base year that is at least  
 15.13 three standard deviations above the statewide mean utilization rate shall receive a factor of  
 15.14 0.3711.

15.15 (e) Any payments or portion of payments made to a hospital under this subdivision that  
 15.16 are subsequently returned to the commissioner because the payments are found to exceed  
 15.17 the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the  
 15.18 number of fee-for-service discharges, to other DSH-eligible ~~nonchildren's~~ non-children's  
 15.19 hospitals that have a medical assistance utilization rate that is at least one standard deviation  
 15.20 above the mean.

15.21 **EFFECTIVE DATE.** This section is effective July 1, 2017.

15.22 Sec. 12. Minnesota Statutes 2016, section 256.969, subdivision 12, is amended to read:

15.23 Subd. 12. **Rehabilitation hospitals and distinct parts.** (a) Units of hospitals that are  
 15.24 recognized as rehabilitation distinct parts by the Medicare program shall have separate  
 15.25 provider numbers under the medical assistance program for rate establishment and billing  
 15.26 purposes only. These units shall also have operating payment rates and the disproportionate  
 15.27 population adjustment, if allowed by federal law, established separately from other inpatient  
 15.28 hospital services.

15.29 (b) The commissioner shall establish separate relative values under subdivision 2 for  
 15.30 rehabilitation hospitals and distinct parts as defined by the Medicare program. Effective for  
 15.31 discharges occurring on and after November 1, 2014, the commissioner, to the extent  
 15.32 possible, shall replicate the existing payment rate methodology under the new diagnostic  
 15.33 classification system. The result must be budget neutral, ensuring that the total aggregate  
 16.1 payments under the new system are equal to the total aggregate payments made for the same  
 16.2 number and types of services in the base year, calendar year 2012.

16.3 (c) For individual hospitals that did not have separate medical assistance rehabilitation  
 16.4 provider numbers or rehabilitation distinct parts in the base year, hospitals shall provide the  
 16.5 information needed to separate rehabilitation distinct part cost and claims data from other  
 16.6 inpatient service data.

16.7 (d) Effective with discharges on or after July 1, 2017, payment to rehabilitation hospitals  
 16.8 shall be established under subdivision 2b, paragraph (a), clause (4).

16.9 **EFFECTIVE DATE.** This section is effective July 1, 2017.

168.20 Sec. 11. **[256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

- 168.21 Subdivision 1. **Contract for dental administration services.** (a) The commissioner  
168.22 shall contract with up to two dental administrators to administer dental services for all  
168.23 recipients of medical assistance and MinnesotaCare.
- 168.24 (b) The dental administrator must provide administrative services, including, but not  
168.25 limited to:
- 168.26 (1) provider recruitment, contracting, and assistance;
- 168.27 (2) recipient outreach and assistance;
- 168.28 (3) utilization management and review for medical necessity of dental services;
- 168.29 (4) dental claims processing, including submission of encounter claims to the department;
- 168.30 (5) coordination with other services;
- 169.1 (6) management of fraud and abuse;
- 169.2 (7) monitoring of access to dental services;
- 169.3 (8) performance measurement;
- 169.4 (9) quality improvement and evaluation requirements; and
- 169.5 (10) management of third party liability requirements.
- 169.6 (c) A payment to a contracted dental provider shall be at the rates established under  
169.7 section 256B.76.
- 169.8 Subd. 2. **Requirements.** (a) Recipients shall be given a choice of dental provider,  
169.9 including any provider who agrees to the provider participation requirements and payment  
169.10 rates established under this section. The commissioner and dental services administrator  
169.11 shall comply with the network adequacy, geographic access, and essential community  
169.12 provider requirements that apply to managed care plans and county-based purchasing plans  
169.13 for nondental services.
- 169.14 (b) The commissioner shall implement this section in consultation with representatives  
169.15 of providers who provide dental services to patients enrolled in medical assistance or

169.16 MinnesotaCare, including, but not limited to, providers who serve primarily low-income  
 169.17 and socioeconomically complex patient populations.

169.18 (c) The commissioner shall consult with county-based purchasing plans on the  
 169.19 development and review of a request for proposals, and development of metrics to evaluate  
 169.20 the performance of a dental administrator. A contract between the commissioner and a  
 169.21 dental administrator must ensure that the administrator coordinates and works with  
 169.22 county-based purchasing plans to assist enrollees in accessing appropriate dental care within  
 169.23 their geographic areas.

169.24 **EFFECTIVE DATE.** This section is effective January 1, 2018.

16.10 Sec. 13. Minnesota Statutes 2016, section 256B.04, subdivision 12, is amended to read:

16.11 Subd. 12. **Limitation on services.** (a) Place limits on the types of services covered by  
 16.12 medical assistance, the frequency with which the same or similar services may be covered  
 16.13 by medical assistance for an individual recipient, and the amount paid for each covered  
 16.14 service. The state agency shall promulgate rules establishing maximum reimbursement rates  
 16.15 for emergency and nonemergency transportation.

16.16 The rules shall provide:

16.17 (1) an opportunity for all recognized transportation providers to be reimbursed for  
 16.18 nonemergency transportation consistent with the maximum rates established by the agency;  
 16.19 and

16.20 (2) reimbursement of public and private nonprofit providers serving the disabled  
 16.21 population generally at reasonable maximum rates that reflect the cost of providing the  
 16.22 service regardless of the fare that might be charged by the provider for similar services to  
 16.23 individuals other than those receiving medical assistance or medical care under this chapter;  
 16.24 and.

16.25 ~~(3) reimbursement for each additional passenger carried on a single trip at a substantially~~  
 16.26 ~~lower rate than the first passenger carried on that trip.~~

16.27 (b) The commissioner shall encourage providers reimbursed under this chapter to  
 16.28 coordinate their operation with similar services that are operating in the same community.  
 16.29 To the extent practicable, the commissioner shall encourage eligible individuals to utilize  
 16.30 less expensive providers capable of serving their needs.

169.25 Sec. 12. Minnesota Statutes 2016, section 256B.04, subdivision 21, is amended to read:

169.26 Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct  
 169.27 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart  
 169.28 E, including database checks, unannounced pre- and post-enrollment site visits, fingerprinting,  
 169.29 and criminal background studies. A provider providing services from multiple locations  
 169.30 must enroll each location separately. The commissioner may deny a provider's incomplete  
 169.31 application for enrollment if a provider fails to respond to the commissioner's request for  
 169.32 additional information within 60 days of the request.

170.1 (b) The commissioner must revalidate each provider under this subdivision at least once  
 170.2 every five years. The commissioner may revalidate a personal care assistance agency under  
 170.3 this subdivision once every three years. The commissioner shall conduct revalidation as  
 170.4 follows:

170.5 (1) provide 30-day notice of revalidation due date to include instructions for revalidation  
 170.6 and a list of materials the provider must submit to revalidate;

170.7 (2) notify the provider that fails to completely respond within 30 days of any deficiencies  
 170.8 and allow an additional 30 days to comply; and

170.9 (3) give 60-day notice of termination and immediately suspend a provider's ability to  
 170.10 bill for failure to remedy any deficiencies within the 30-day time period. The provider shall  
 170.11 have no right to appeal suspension of ability to bill.

170.12 (c) The commissioner may suspend a provider's ability to bill for a failure to comply  
 170.13 with any individual provider requirements or conditions of participation until the provider  
 170.14 comes into compliance. The commissioner's decision to suspend the provider is not subject  
 170.15 to an administrative appeal.

170.16 (d) Notwithstanding any other provision to the contrary, all correspondence and  
 170.17 notifications, including notifications of termination and other actions, shall be delivered

16.31 (c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective  
 16.32 on January 1, 1981, "recognized provider of transportation services" means an operator of  
 17.1 special transportation service as defined in section 174.29 that has been issued a current  
 17.2 certificate of compliance with operating standards of the commissioner of transportation  
 17.3 or, if those standards do not apply to the operator, that the agency finds is able to provide  
 17.4 the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized  
 17.5 transportation provider" includes an operator of special transportation service that the agency  
 17.6 finds is able to provide the required transportation in a safe and reliable manner.

170.18 ~~electronically to a provider's MN-ITS mailbox. For a provider that does not have a MN-ITS~~  
170.19 ~~account and mailbox, notice shall be sent by first class mail.~~

170.20 ~~(e) If the commissioner or the Centers for Medicare and Medicaid Services determines~~  
170.21 ~~that a provider is designated "high-risk," the commissioner may withhold payment from~~  
170.22 ~~providers within that category upon initial enrollment for a 90-day period. The withholding~~  
170.23 ~~for each provider must begin on the date of the first submission of a claim.~~

170.24 ~~(b) (f) An enrolled provider that is also licensed by the commissioner under chapter~~  
170.25 ~~245A, or is licensed as a home care provider by the Department of Health under chapter~~  
170.26 ~~144A and has a home and community-based services designation on the home care license~~  
170.27 ~~under section 144A.484, must designate an individual as the entity's compliance officer.~~  
170.28 ~~The compliance officer must:~~

170.29 ~~(1) develop policies and procedures to assure adherence to medical assistance laws and~~  
170.30 ~~regulations and to prevent inappropriate claims submissions;~~

170.31 ~~(2) train the employees of the provider entity, and any agents or subcontractors of the~~  
170.32 ~~provider entity including billers, on the policies and procedures under clause (1);~~

171.1 ~~(3) respond to allegations of improper conduct related to the provision or billing of~~  
171.2 ~~medical assistance services, and implement action to remediate any resulting problems;~~

171.3 ~~(4) use evaluation techniques to monitor compliance with medical assistance laws and~~  
171.4 ~~regulations;~~

171.5 ~~(5) promptly report to the commissioner any identified violations of medical assistance~~  
171.6 ~~laws or regulations; and~~

171.7 ~~(6) within 60 days of discovery by the provider of a medical assistance reimbursement~~  
171.8 ~~overpayment, report the overpayment to the commissioner and make arrangements with~~  
171.9 ~~the commissioner for the commissioner's recovery of the overpayment.~~

171.10 ~~The commissioner may require, as a condition of enrollment in medical assistance, that a~~  
171.11 ~~provider within a particular industry sector or category establish a compliance program that~~  
171.12 ~~contains the core elements established by the Centers for Medicare and Medicaid Services.~~

171.13 ~~(e) (g) The commissioner may revoke the enrollment of an ordering or rendering provider~~  
171.14 ~~for a period of not more than one year, if the provider fails to maintain and, upon request~~  
171.15 ~~from the commissioner, provide access to documentation relating to written orders or requests~~  
171.16 ~~for payment for durable medical equipment, certifications for home health services, or~~  
171.17 ~~referrals for other items or services written or ordered by such provider, when the~~

171.18 commissioner has identified a pattern of a lack of documentation. A pattern means a failure  
171.19 to maintain documentation or provide access to documentation on more than one occasion.  
171.20 Nothing in this paragraph limits the authority of the commissioner to sanction a provider  
171.21 under the provisions of section 256B.064.

171.22 ~~(h)~~ (h) The commissioner shall terminate or deny the enrollment of any individual or  
171.23 entity if the individual or entity has been terminated from participation in Medicare or under  
171.24 the Medicaid program or Children's Health Insurance Program of any other state.

171.25 ~~(i)~~ (i) As a condition of enrollment in medical assistance, the commissioner shall require  
171.26 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and  
171.27 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid  
171.28 Services, its agents, or its designated contractors and the state agency, its agents, or its  
171.29 designated contractors to conduct unannounced on-site inspections of any provider location.  
171.30 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a  
171.31 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria  
171.32 and standards used to designate Medicare providers in Code of Federal Regulations, title  
171.33 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.  
171.34 The commissioner's designations are not subject to administrative appeal.

172.1 ~~(j)~~ (j) As a condition of enrollment in medical assistance, the commissioner shall require  
172.2 that a high-risk provider, or a person with a direct or indirect ownership interest in the  
172.3 provider of five percent or higher, consent to criminal background checks, including  
172.4 fingerprinting, when required to do so under state law or by a determination by the  
172.5 commissioner or the Centers for Medicare and Medicaid Services that a provider is designated  
172.6 high-risk for fraud, waste, or abuse.

172.7 ~~(k)~~ (k)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all  
172.8 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers  
172.9 meeting the durable medical equipment provider and supplier definition in clause (3),  
172.10 operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is  
172.11 annually renewed and designates the Minnesota Department of Human Services as the  
172.12 obligee, and must be submitted in a form approved by the commissioner. For purposes of  
172.13 this clause, the following medical suppliers are not required to obtain a surety bond: a  
172.14 federally qualified health center, a home health agency, the Indian Health Service, a  
172.15 pharmacy, and a rural health clinic.

172.16 (2) At the time of initial enrollment or reenrollment, durable medical equipment providers  
172.17 and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating  
172.18 provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,  
172.19 the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's  
172.20 Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must



172.21 purchase a surety bond of \$100,000. The surety bond must allow for recovery of costs and  
172.22 fees in pursuing a claim on the bond.

172.23 (3) "Durable medical equipment provider or supplier" means a medical supplier that can  
172.24 purchase medical equipment or supplies for sale or rental to the general public and is able  
172.25 to perform or arrange for necessary repairs to and maintenance of equipment offered for  
172.26 sale or rental.

172.27 ~~(h)~~ (l) The Department of Human Services may require a provider to purchase a surety  
172.28 bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment  
172.29 if: (1) the provider fails to demonstrate financial viability, (2) the department determines  
172.30 there is significant evidence of or potential for fraud and abuse by the provider, or (3) the  
172.31 provider or category of providers is designated high-risk pursuant to paragraph ~~(a)~~ (e) and  
172.32 as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in  
172.33 an amount of \$100,000 or ten percent of the provider's payments from Medicaid during the  
172.34 immediately preceding 12 months, whichever is greater. The surety bond must name the  
172.35 Department of Human Services as an obligee and must allow for recovery of costs and fees  
173.1 in pursuing a claim on the bond. This paragraph does not apply if the provider currently  
173.2 maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

173.3 **EFFECTIVE DATE.** This section is effective July 1, 2017.

173.4 Sec. 13. Minnesota Statutes 2016, section 256B.04, subdivision 22, is amended to read:

173.5 Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally  
173.6 required nonrefundable application fees to pay for provider screening activities in accordance  
173.7 with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application  
173.8 must be made under the procedures specified by the commissioner, in the form specified  
173.9 by the commissioner, and accompanied by an application fee described in paragraph (b),  
173.10 or a request for a hardship exception as described in the specified procedures. Application  
173.11 fees must be deposited in the provider screening account in the special revenue fund.  
173.12 Amounts in the provider screening account are appropriated to the commissioner for costs  
173.13 associated with the provider screening activities required in Code of Federal Regulations,  
173.14 title 42, section 455, subpart E. The commissioner ~~shall conduct screening activities as~~  
173.15 ~~required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise~~  
173.16 ~~provided by law, to include database checks, unannounced pre- and postenrollment site~~  
173.17 ~~visits, fingerprinting, and criminal background studies. The commissioner must revalidate~~  
173.18 ~~all providers under this subdivision at least once every five years must revalidate all personal~~  
173.19 ~~care assistance agencies under this subdivision at least once every three years.~~

173.20 (b) The application fee under this subdivision is \$532 for the calendar year 2013. For  
173.21 calendar year 2014 and subsequent years, the fee:

- 173.22 (1) is adjusted by the percentage change to the Consumer Price Index for all urban  
173.23 consumers, United States city average, for the 12-month period ending with June of the  
173.24 previous year. The resulting fee must be announced in the Federal Register;
- 173.25 (2) is effective from January 1 to December 31 of a calendar year;
- 173.26 (3) is required on the submission of an initial application, an application to establish a  
173.27 new practice location, an application for reenrollment when the provider is not enrolled at  
173.28 the time of application of reenrollment, or at revalidation when required by federal regulation;  
173.29 and
- 173.30 (4) must be in the amount in effect for the calendar year during which the application  
173.31 for enrollment, new practice location, or reenrollment is being submitted.
- 173.32 (c) The application fee under this subdivision cannot be charged to:
- 174.1 (1) providers who are enrolled in Medicare or who provide documentation of payment  
174.2 of the fee to, and enrollment with, another state, unless the commissioner is required to  
174.3 rescreen the provider;
- 174.4 (2) providers who are enrolled but are required to submit new applications for purposes  
174.5 of reenrollment;
- 174.6 (3) a provider who enrolls as an individual; and
- 174.7 (4) group practices and clinics that bill on behalf of individually enrolled providers  
174.8 within the practice who have reassigned their billing privileges to the group practice or  
174.9 clinic.
- 174.10 **EFFECTIVE DATE.** This section is effective July 1, 2017.
- 174.11 Sec. 14. Minnesota Statutes 2016, section 256B.056, subdivision 5c, is amended to read:
- 174.12 Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and  
174.13 caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard  
174.14 specified in subdivision 4, paragraph (b).
- 174.15 (b) The excess income standard for a person whose eligibility is based on blindness,  
174.16 disability, or age of 65 or more years shall equal ~~80~~ 81 percent of the federal poverty  
174.17 guidelines.

174.18 **EFFECTIVE DATE.** This section is effective June 1, 2019.

174.19 Sec. 15. Minnesota Statutes 2016, section 256B.0621, subdivision 10, is amended to read:

174.20 Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case  
174.21 management under this subdivision. Case managers may bill according to the following  
174.22 criteria:

174.23 (1) for relocation targeted case management, case managers may bill for direct case  
174.24 management activities, including face-to-face ~~and contact, telephone ~~contacts~~ contact, and~~  
174.25 interactive video contact according to section 256B.0924, subdivision 4a, in the lesser of:

174.26 (i) 180 days preceding an eligible recipient's discharge from an institution; or

174.27 (ii) the limits and conditions which apply to federal Medicaid funding for this service;

174.28 (2) for home care targeted case management, case managers may bill for direct case  
174.29 management activities, including face-to-face and telephone contacts; and

175.1 (3) billings for targeted case management services under this subdivision shall not  
175.2 duplicate payments made under other program authorities for the same purpose.

175.3 **EFFECTIVE DATE.** This section is effective three months after federal approval.

175.4 Sec. 16. Minnesota Statutes 2016, section 256B.0625, subdivision 3b, is amended to read:

175.5 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary  
175.6 services and consultations delivered by a licensed health care provider via telemedicine in  
175.7 the same manner as if the service or consultation was delivered in person. Coverage is  
175.8 limited to three telemedicine services per enrollee per calendar week. Telemedicine services  
175.9 shall be paid at the full allowable rate.

175.10 (b) The commissioner shall establish criteria that a health care provider must attest to  
175.11 in order to demonstrate the safety or efficacy of delivering a particular service via  
175.12 telemedicine. The attestation may include that the health care provider:

#### THE FOLLOWING SECTION IS FROM HOUSE ARTICLE 6.

274.10 Sec. 13. Minnesota Statutes 2016, section 256B.0621, subdivision 10, is amended to read:

274.11 Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case  
274.12 management under this subdivision. Case managers may bill according to the following  
274.13 criteria:

274.14 (1) for relocation targeted case management, case managers may bill for direct case  
274.15 management activities, including face-to-face ~~and contact, telephone ~~contacts~~ contact, and~~  
274.16 interactive video contact according to section 256B.0924, subdivision 4a, in the lesser of:

274.17 (i) 180 days preceding an eligible recipient's discharge from an institution; or

274.18 (ii) the limits and conditions which apply to federal Medicaid funding for this service;

274.19 (2) for home care targeted case management, case managers may bill for direct case  
274.20 management activities, including face-to-face and telephone contacts; and

274.21 (3) billings for targeted case management services under this subdivision shall not  
274.22 duplicate payments made under other program authorities for the same purpose.

#### THE FOLLOWING SECTIONS ARE FROM HOUSE ARTICLE 1.

17.7 Sec. 14. Minnesota Statutes 2016, section 256B.0625, subdivision 3b, is amended to read:

17.8 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary  
17.9 services and consultations delivered by a licensed health care provider via telemedicine in  
17.10 the same manner as if the service or consultation was delivered in person. Coverage is  
17.11 limited to three telemedicine services per enrollee per calendar week. Telemedicine services  
17.12 shall be paid at the full allowable rate.

17.13 (b) The commissioner shall establish criteria that a health care provider must attest to  
17.14 in order to demonstrate the safety or efficacy of delivering a particular service via  
17.15 telemedicine. The attestation may include that the health care provider:

175.13 (1) has identified the categories or types of services the health care provider will provide  
175.14 via telemedicine;

175.15 (2) has written policies and procedures specific to telemedicine services that are regularly  
175.16 reviewed and updated;

175.17 (3) has policies and procedures that adequately address patient safety before, during,  
175.18 and after the telemedicine service is rendered;

175.19 (4) has established protocols addressing how and when to discontinue telemedicine  
175.20 services; and

175.21 (5) has an established quality assurance process related to telemedicine services.

175.22 (c) As a condition of payment, a licensed health care provider must document each  
175.23 occurrence of a health service provided by telemedicine to a medical assistance enrollee.  
175.24 Health care service records for services provided by telemedicine must meet the requirements  
175.25 set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

175.26 (1) the type of service provided by telemedicine;

175.27 (2) the time the service began and the time the service ended, including an a.m. and p.m.  
175.28 designation;

175.29 (3) the licensed health care provider's basis for determining that telemedicine is an  
175.30 appropriate and effective means for delivering the service to the enrollee;

176.1 (4) the mode of transmission of the telemedicine service and records evidencing that a  
176.2 particular mode of transmission was utilized;

176.3 (5) the location of the originating site and the distant site;

176.4 (6) if the claim for payment is based on a physician's telemedicine consultation with  
176.5 another physician, the written opinion from the consulting physician providing the  
176.6 telemedicine consultation; and

176.7 (7) compliance with the criteria attested to by the health care provider in accordance  
176.8 with paragraph (b).

176.9 (d) For purposes of this subdivision, unless otherwise covered under this chapter,  
176.10 "telemedicine" is defined as the delivery of health care services or consultations while the

17.16 (1) has identified the categories or types of services the health care provider will provide  
17.17 via telemedicine;

17.18 (2) has written policies and procedures specific to telemedicine services that are regularly  
17.19 reviewed and updated;

17.20 (3) has policies and procedures that adequately address patient safety before, during,  
17.21 and after the telemedicine service is rendered;

17.22 (4) has established protocols addressing how and when to discontinue telemedicine  
17.23 services; and

17.24 (5) has an established quality assurance process related to telemedicine services.

17.25 (c) As a condition of payment, a licensed health care provider must document each  
17.26 occurrence of a health service provided by telemedicine to a medical assistance enrollee.  
17.27 Health care service records for services provided by telemedicine must meet the requirements  
17.28 set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

17.29 (1) the type of service provided by telemedicine;

17.30 (2) the time the service began and the time the service ended, including an a.m. and p.m.  
17.31 designation;

18.1 (3) the licensed health care provider's basis for determining that telemedicine is an  
18.2 appropriate and effective means for delivering the service to the enrollee;

18.3 (4) the mode of transmission of the telemedicine service and records evidencing that a  
18.4 particular mode of transmission was utilized;

18.5 (5) the location of the originating site and the distant site;

18.6 (6) if the claim for payment is based on a physician's telemedicine consultation with  
18.7 another physician, the written opinion from the consulting physician providing the  
18.8 telemedicine consultation; and

18.9 (7) compliance with the criteria attested to by the health care provider in accordance  
18.10 with paragraph (b).

18.11 (d) For purposes of this subdivision, unless otherwise covered under this chapter,  
18.12 "telemedicine" is defined as the delivery of health care services or consultations while the

176.11 patient is at an originating site and the licensed health care provider is at a distant site. A  
 176.12 communication between licensed health care providers, or a licensed health care provider  
 176.13 and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission  
 176.14 does not constitute telemedicine consultations or services. Telemedicine may be provided  
 176.15 by means of real-time two-way, interactive audio and visual communications, including the  
 176.16 application of secure video conferencing or store-and-forward technology to provide or  
 176.17 support health care delivery, which facilitate the assessment, diagnosis, consultation,  
 176.18 treatment, education, and care management of a patient's health care.

176.19 (e) For purposes of this section, "licensed health care provider" is defined under section  
 176.20 62A.671, subdivision 6, and includes a mental health practitioner as defined under section  
 176.21 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision  
 176.22 of a mental health professional; "health care provider" is defined under section 62A.671,  
 176.23 subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

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

176.25 Sec. 17. Minnesota Statutes 2016, section 256B.0625, subdivision 7, is amended to read:

176.26 Subd. 7. **Home care nursing.** Medical assistance covers home care nursing services in  
 176.27 a recipient's home. Recipients who are authorized to receive home care nursing services in  
 176.28 their home may use approved hours outside of the home during hours when normal life  
 176.29 activities take them outside of their home. To use home care nursing services at school, the  
 176.30 recipient or responsible party must provide written authorization in the care plan identifying  
 176.31 the chosen provider and the daily amount of services to be used at school. Medical assistance  
 176.32 does not cover home care nursing services for residents of a hospital, nursing facility,  
 176.33 intermediate care facility, or a health care facility licensed by the commissioner of health,  
 177.1 ~~except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or~~  
 177.2 ~~unless a resident who is otherwise eligible is on leave from the facility and the facility either~~  
 177.3 ~~pays for the home care nursing services or forgoes the facility per diem for the leave days~~  
 177.4 ~~that home care nursing services are used. Total hours of service and payment allowed for~~  
 177.5 ~~services outside the home cannot exceed that which is otherwise allowed in an in-home~~  
 177.6 ~~setting according to sections 256B.0651 and 256B.0654. All home care nursing services~~  
 177.7 ~~must be provided according to the limits established under sections 256B.0651, 256B.0653,~~  
 177.8 ~~and 256B.0654. Home care nursing services may not be reimbursed if the nurse is the family~~  
 177.9 ~~foster care provider of a recipient who is under age 18, unless allowed under section~~  
 177.10 ~~256B.0654, subdivision 4.~~

18.13 patient is at an originating site and the licensed health care provider is at a distant site. A  
 18.14 communication between licensed health care providers, or a licensed health care provider  
 18.15 and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission  
 18.16 does not constitute telemedicine consultations or services. Telemedicine may be provided  
 18.17 by means of real-time two-way, interactive audio and visual communications, including the  
 18.18 application of secure video conferencing or store-and-forward technology to provide or  
 18.19 support health care delivery, which facilitate the assessment, diagnosis, consultation,  
 18.20 treatment, education, and care management of a patient's health care.

18.21 (e) For purposes of this section, "licensed health care provider" is defined means a  
 18.22 licensed health care provider under section 62A.671, subdivision 6, and a mental health  
 18.23 practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26,  
 18.24 working under the general supervision of a mental health professional; "health care provider"  
 18.25 is defined under section 62A.671, subdivision 3; and "originating site" is defined under  
 18.26 section 62A.671, subdivision 7.

18.27 Sec. 15. Minnesota Statutes 2016, section 256B.0625, subdivision 13, is amended to read:

18.28 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when  
 18.29 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed  
 18.30 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a  
 18.31 dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed  
 18.32 by or under contract with a community health board as defined in section 145A.02,  
 18.33 subdivision 5, for the purposes of communicable disease control.

19.1 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,  
 19.2 unless authorized by the commissioner.

19.3 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical  
 19.4 ingredient" is defined as a substance that is represented for use in a drug and when used in  
 19.5 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the  
 19.6 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle  
 19.7 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and  
 19.8 excipients which are included in the medical assistance formulary. Medical assistance covers  
 19.9 selected active pharmaceutical ingredients and excipients used in compounded prescriptions  
 19.10 when the compounded combination is specifically approved by the commissioner or when  
 19.11 a commercially available product:

19.12 (1) is not a therapeutic option for the patient;

19.13 (2) does not exist in the same combination of active ingredients in the same strengths  
 19.14 as the compounded prescription; and

19.15 (3) cannot be used in place of the active pharmaceutical ingredient in the compounded  
 19.16 prescription.

19.17 (d) Medical assistance covers the following over-the-counter drugs when prescribed by  
 19.18 a licensed practitioner or by a licensed pharmacist who meets standards established by the  
 19.19 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family  
 19.20 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults  
 19.21 with documented vitamin deficiencies, vitamins for children under the age of seven and  
 19.22 pregnant or nursing women, and any other over-the-counter drug identified by the  
 19.23 commissioner, in consultation with the formulary committee, as necessary, appropriate, and  
 19.24 cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders,  
 19.25 and this determination shall not be subject to the requirements of chapter 14. A pharmacist  
 19.26 may prescribe over-the-counter medications as provided under this paragraph for purposes  
 19.27 of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under  
 19.28 this paragraph, licensed pharmacists must consult with the recipient to determine necessity,  
 19.29 provide drug counseling, review drug therapy for potential adverse interactions, and make  
 19.30 referrals as needed to other health care professionals. ~~Over the counter medications must~~  
 19.31 ~~be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained in~~

19.32 ~~the manufacturer's original package; (2) the number of dosage units required to complete~~  
 19.33 ~~the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed~~  
 20.1 ~~from a system using retrospective billing, as provided under subdivision 13e, paragraph~~  
 20.2 ~~(b).~~

20.3 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable  
 20.4 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and  
 20.5 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible  
 20.6 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and  
 20.7 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these  
 20.8 individuals, medical assistance may cover drugs from the drug classes listed in United States  
 20.9 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to  
 20.10 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall  
 20.11 not be covered.

20.12 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing  
 20.13 Program and dispensed by 340B covered entities and ambulatory pharmacies under common  
 20.14 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired  
 20.15 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

20.16 Sec. 16. Minnesota Statutes 2016, section 256B.0625, subdivision 13e, is amended to  
 20.17 read:

20.18 Subd. 13e. **Payment rates.** (a) Effective April 1, 2017, or upon federal approval,  
 20.19 whichever is later, the basis for determining the amount of payment shall be the lower of  
 20.20 the ~~actual acquisition costs~~ ingredient cost of the drugs ~~or the maximum allowable cost by~~  
 20.21 ~~the commissioner~~ plus the ~~fixed~~ professional dispensing fee; or the usual and customary  
 20.22 price charged to the public. The usual and customary price is defined as the lowest price  
 20.23 charged by the provider to a patient who pays for the prescription by cash, check, or charge  
 20.24 account and includes those prices the pharmacy charges to customers enrolled in a  
 20.25 prescription savings club or prescription discount club administered by the pharmacy or  
 20.26 pharmacy chain. The amount of payment basis must be reduced to reflect all discount  
 20.27 amounts applied to the charge by any third-party provider/insurer agreement or contract for  
 20.28 submitted charges to medical assistance programs. The net submitted charge may not be  
 20.29 greater than the patient liability for the service. The ~~pharmacy~~ professional dispensing fee  
 20.30 shall be ~~\$3.65~~ \$11.35 for ~~legend prescription drugs~~ prescriptions filled with legend drugs  
 20.31 meeting the definition of "covered outpatient drugs" according to United States Code, title  
 20.32 42, section 1396r-8(k)(2), except that the dispensing fee for intravenous solutions which  
 20.33 must be compounded by the pharmacist shall be ~~\$8~~ \$11.35 per bag, ~~\$14 per bag for cancer~~  
 20.34 ~~chemotherapy products, and \$30 per bag for total parenteral nutritional products dispensed~~  
 21.1 ~~in one liter quantities, or \$44 per bag for total parenteral nutritional products dispensed in~~  
 21.2 ~~quantities greater than one liter. The professional dispensing fee for prescriptions filled with~~  
 21.3 ~~over-the-counter drugs meeting the definition of covered outpatient drugs shall be \$11.35~~

21.4 for dispensed quantities equal to or greater than the number of units contained in the  
 21.5 manufacturer's original package. The professional dispensing fee shall be prorated based  
 21.6 on the percentage of the package dispensed when the pharmacy dispenses a quantity less  
 21.7 than the number of units contained in the manufacturer's original package. The pharmacy  
 21.8 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered  
 21.9 outpatient drugs shall be \$3.65, except that the fee shall be \$1.31 for retrospectively billing  
 21.10 pharmacies when billing for quantities less than the number of units contained in the  
 21.11 manufacturer's original package. Actual acquisition cost includes quantity and other special  
 21.12 discounts except time and cash discounts. The actual acquisition for quantities equal to or  
 21.13 greater than the number of units contained in the manufacturer's original package and shall  
 21.14 be prorated based on the percentage of the package dispensed when the pharmacy dispenses  
 21.15 a quantity less than the number of units contained in the manufacturer's original package.  
 21.16 The National Average Drug Acquisition Cost (NADAC) shall be used to determine the  
 21.17 ingredient cost of a drug shall be estimated by the commissioner at wholesale acquisition  
 21.18 cost plus four percent for independently owned pharmacies located in a designated rural  
 21.19 area within Minnesota, and at wholesale acquisition cost plus two percent for all other  
 21.20 pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies  
 21.21 under the same ownership nationally. A "designated rural area" means an area defined as  
 21.22 a small rural area or isolated rural area according to the four category classification of the  
 21.23 Rural Urban Commuting Area system developed for the United States Health Resources  
 21.24 and Services Administration. Effective January 1, 2014, the actual acquisition. For drugs  
 21.25 for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at  
 21.26 wholesale acquisition cost minus two percent. The commissioner shall establish the ingredient  
 21.27 cost of a drug acquired through the federal 340B Drug Pricing Program shall be estimated  
 21.28 by the commissioner at wholesale acquisition cost minus 40 percent at a 340B Drug Pricing  
 21.29 Program maximum allowable cost. The 340B Drug Pricing Program maximum allowable  
 21.30 cost shall be comparable to, but no higher than, the 340B Drug Pricing Program ceiling  
 21.31 price established by the Health Resources and Services Administration. Wholesale acquisition  
 21.32 cost is defined as the manufacturer's list price for a drug or biological to wholesalers or  
 21.33 direct purchasers in the United States, not including prompt pay or other discounts, rebates,  
 21.34 or reductions in price, for the most recent month for which information is available, as  
 21.35 reported in wholesale price guides or other publications of drug or biological pricing data.  
 21.36 The maximum allowable cost of a multisource drug may be set by the commissioner and it  
 22.1 shall be comparable to, but the actual acquisition cost of the drug product and no higher  
 22.2 than, the maximum amount paid by other third-party payors in this state who have maximum  
 22.3 allowable cost programs and no higher than the NADAC of the generic product.  
 22.4 Establishment of the amount of payment for drugs shall not be subject to the requirements  
 22.5 of the Administrative Procedure Act.

22.6 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using  
 22.7 an automated drug distribution system meeting the requirements of section 151.58, or a  
 22.8 packaging system meeting the packaging standards set forth in Minnesota Rules, part  
 22.9 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ  
 22.10 retrospective billing for prescription drugs dispensed to long-term care facility residents. A



22.11 retrospectively billing pharmacy must submit a claim only for the quantity of medication  
 22.12 used by the enrolled recipient during the defined billing period. A retrospectively billing  
 22.13 pharmacy must use a billing period not less than one calendar month or 30 days.

22.14 (c) An additional dispensing fee of \$.30 may be added to the dispensing fee paid to  
 22.15 pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities  
 22.16 when a unit dose blister card system, approved by the department, is used. Under this type  
 22.17 of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National  
 22.18 Drug Code (NDC) from the drug container used to fill the blister card must be identified  
 22.19 on the claim to the department. The unit dose blister card containing the drug must meet  
 22.20 the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return  
 22.21 of unused drugs to the pharmacy for reuse. A pharmacy provider using packaging that meets  
 22.22 the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the  
 22.23 department for the actual acquisition cost of all unused drugs that are eligible for reuse,  
 22.24 unless the pharmacy is using retrospective billing. The commissioner may permit the drug  
 22.25 clozapine to be dispensed in a quantity that is less than a 30-day supply.

22.26 (d) Whenever a maximum allowable cost has been set for If a pharmacy dispenses a  
 22.27 multisource drug, payment shall be the lower of the usual and customary price charged to  
 22.28 the public or the ingredient cost shall be the NADAC of the generic product or the maximum  
 22.29 allowable cost established by the commissioner unless prior authorization for the brand  
 22.30 name product has been granted according to the criteria established by the Drug Formulary  
 22.31 Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated  
 22.32 "dispense as written" on the prescription in a manner consistent with section 151.21,  
 22.33 subdivision 2.

22.34 (e) The basis for determining the amount of payment for drugs administered in an  
 22.35 outpatient setting shall be the lower of the usual and customary cost submitted by the  
 23.1 provider, 106 percent of the average sales price as determined by the United States  
 23.2 Department of Health and Human Services pursuant to title XVIII, section 1847a of the  
 23.3 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost  
 23.4 set by the commissioner. If average sales price is unavailable, the amount of payment must  
 23.5 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition  
 23.6 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.  
 23.7 Effective January 1, 2014, the commissioner shall discount the payment rate for drugs  
 23.8 obtained through the federal 340B Drug Pricing Program by 20 percent. The payment for  
 23.9 drugs administered in an outpatient setting shall be made to the administering facility or  
 23.10 practitioner. A retail or specialty pharmacy dispensing a drug for administration in an  
 23.11 outpatient setting is not eligible for direct reimbursement.

23.12 (f) The commissioner may negotiate lower reimbursement rates establish maximum  
 23.13 allowable cost rates for specialty pharmacy products than the rates that are lower than the  
 23.14 ingredient cost formulas specified in paragraph (a). The commissioner may require

- 23.15 individuals enrolled in the health care programs administered by the department to obtain  
 23.16 specialty pharmacy products from providers ~~with whom the commissioner has negotiated~~  
 23.17 ~~lower reimbursement rates~~ able to provide enhanced clinical services and willing to accept  
 23.18 the specialty pharmacy reimbursement. Specialty pharmacy products are defined as those  
 23.19 used by a small number of recipients or recipients with complex and chronic diseases that  
 23.20 require expensive and challenging drug regimens. Examples of these conditions include,  
 23.21 but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth  
 23.22 hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer.  
 23.23 Specialty pharmaceutical products include injectable and infusion therapies, biotechnology  
 23.24 drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex  
 23.25 care. The commissioner shall consult with the formulary committee to develop a list of  
 23.26 specialty pharmacy products subject to ~~this paragraph~~ maximum allowable cost  
 23.27 reimbursement. In consulting with the formulary committee in developing this list, the  
 23.28 commissioner shall take into consideration the population served by specialty pharmacy  
 23.29 products, the current delivery system and standard of care in the state, and access to care  
 23.30 issues. The commissioner shall have the discretion to adjust the ~~reimbursement rate~~ maximum  
 23.31 allowable cost to prevent access to care issues.
- 23.32 (g) Home infusion therapy services provided by home infusion therapy pharmacies must  
 23.33 be paid at rates according to subdivision 8d.
- 23.34 (h) Effective for prescriptions filled on or after April 1, 2017, or upon federal approval,  
 23.35 whichever is later, the commissioner shall increase the ingredient cost reimbursement  
 24.1 calculated in paragraphs (a) and (f) by two percent for prescription and nonprescription  
 24.2 drugs subject to the wholesale drug distributor tax under section 295.52.
- 24.3 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2017, or from  
 24.4 the effective date of federal approval, whichever is later. The commissioner of human  
 24.5 services shall notify the revisor of statutes when federal approval is obtained.
- 24.6 Sec. 17. Minnesota Statutes 2016, section 256B.0625, subdivision 17, is amended to read:
- 24.7 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"  
 24.8 means motor vehicle transportation provided by a public or private person that serves  
 24.9 Minnesota health care program beneficiaries who do not require emergency ambulance  
 24.10 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.
- 24.11 (b) Medical assistance covers medical transportation costs incurred solely for obtaining  
 24.12 emergency medical care or transportation costs incurred by eligible persons in obtaining  
 24.13 emergency or nonemergency medical care when paid directly to an ambulance company,  
 24.14 ~~common carrier nonemergency medical transportation company~~, or other recognized  
 24.15 providers of transportation services. Medical transportation must be provided by:

- 24.16 (1) nonemergency medical transportation providers who meet the requirements of this  
 24.17 subdivision;
- 24.18 (2) ambulances, as defined in section 144E.001, subdivision 2;
- 24.19 (3) taxicabs that meet the requirements of this subdivision;
- 24.20 (4) public transit, as defined in section 174.22, subdivision 7; or
- 24.21 (5) not-for-hire vehicles, including volunteer drivers.
- 24.22 (c) Medical assistance covers nonemergency medical transportation provided by  
 24.23 nonemergency medical transportation providers enrolled in the Minnesota health care  
 24.24 programs. All nonemergency medical transportation providers must comply with the  
 24.25 operating standards for special transportation service as defined in sections 174.29 to 174.30  
 24.26 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota Department of  
 24.27 Transportation. All nonemergency medical transportation providers shall bill for  
 24.28 nonemergency medical transportation services in accordance with Minnesota health care  
 24.29 programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles  
 24.30 are exempt from the requirements outlined in this paragraph.
- 24.31 (d) An organization may be terminated, denied, or suspended from enrollment if:
- 25.1 (1) the provider has not initiated background studies on the individuals specified in  
 25.2 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or
- 25.3 (2) the provider has initiated background studies on the individuals specified in section  
 25.4 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:
- 25.5 (i) the commissioner has sent the provider a notice that the individual has been  
 25.6 disqualified under section 245C.14; and
- 25.7 (ii) the individual has not received a disqualification set-aside specific to the special  
 25.8 transportation services provider under sections 245C.22 and 245C.23.
- 25.9 (e) The administrative agency of nonemergency medical transportation must:
- 25.10 (1) adhere to the policies defined by the commissioner in consultation with the  
 25.11 Nonemergency Medical Transportation Advisory Committee;

- 25.12 (2) pay nonemergency medical transportation providers for services provided to  
 25.13 Minnesota health care programs beneficiaries to obtain covered medical services;
- 25.14 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled  
 25.15 trips, and number of trips by mode; and
- 25.16 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a Web-based single  
 25.17 administrative structure assessment tool that meets the technical requirements established  
 25.18 by the commissioner, reconciles trip information with claims being submitted by providers,  
 25.19 and ensures prompt payment for nonemergency medical transportation services.
- 25.20 (f) Until the commissioner implements the single administrative structure and delivery  
 25.21 system under subdivision 18e, clients shall obtain their level-of-service certificate from the  
 25.22 commissioner or an entity approved by the commissioner that does not dispatch rides for  
 25.23 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).
- 25.24 (g) The commissioner may use an order by the recipient's attending physician or a medical  
 25.25 or mental health professional to certify that the recipient requires nonemergency medical  
 25.26 transportation services. Nonemergency medical transportation providers shall perform  
 25.27 driver-assisted services for eligible individuals, when appropriate. Driver-assisted service  
 25.28 includes passenger pickup at and return to the individual's residence or place of business,  
 25.29 assistance with admittance of the individual to the medical facility, and assistance in  
 25.30 passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.
- 25.31 Nonemergency medical transportation providers must take clients to the health care  
 25.32 provider using the most direct route, and must not exceed 30 miles for a trip to a primary  
 26.1 care provider or 60 miles for a trip to a specialty care provider, unless the client receives  
 26.2 authorization from the local agency.
- 26.3 Nonemergency medical transportation providers may not bill for separate base rates for  
 26.4 the continuation of a trip beyond the original destination. Nonemergency medical  
 26.5 transportation providers must maintain trip logs, which include pickup and drop-off times,  
 26.6 signed by the medical provider or client, whichever is deemed most appropriate, attesting  
 26.7 to mileage traveled to obtain covered medical services. Clients requesting client mileage  
 26.8 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical  
 26.9 services.
- 26.10 (h) The administrative agency shall use the level of service process established by the  
 26.11 commissioner in consultation with the Nonemergency Medical Transportation Advisory  
 26.12 Committee to determine the client's most appropriate mode of transportation. If public transit  
 26.13 or a certified transportation provider is not available to provide the appropriate service mode  
 26.14 for the client, the client may receive a onetime service upgrade.

- 26.15 (i) The covered modes of transportation, which may not be implemented without a new  
26.16 rate structure, are:
- 26.17 (1) client reimbursement, which includes client mileage reimbursement provided to  
26.18 clients who have their own transportation, or to family or an acquaintance who provides  
26.19 transportation to the client;
- 26.20 (2) volunteer transport, which includes transportation by volunteers using their own  
26.21 vehicle;
- 26.22 (3) unassisted transport, which includes transportation provided to a client by a taxicab  
26.23 or public transit. If a taxicab or public transit is not available, the client can receive  
26.24 transportation from another nonemergency medical transportation provider;
- 26.25 (4) assisted transport, which includes transport provided to clients who require assistance  
26.26 by a nonemergency medical transportation provider;
- 26.27 (5) lift-equipped/ramp transport, which includes transport provided to a client who is  
26.28 dependent on a device and requires a nonemergency medical transportation provider with  
26.29 a vehicle containing a lift or ramp;
- 26.30 (6) protected transport, which includes transport provided to a client who has received  
26.31 a prescreening that has deemed other forms of transportation inappropriate and who requires  
26.32 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety  
27.1 locks, a video recorder, and a transparent thermoplastic partition between the passenger and  
27.2 the vehicle driver; and (ii) who is certified as a protected transport provider; and
- 27.3 (7) stretcher transport, which includes transport for a client in a prone or supine position  
27.4 and requires a nonemergency medical transportation provider with a vehicle that can transport  
27.5 a client in a prone or supine position.
- 27.6 (j) The local agency shall be the single administrative agency and shall administer and  
27.7 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the  
27.8 commissioner has developed, made available, and funded the Web-based single  
27.9 administrative structure, assessment tool, and level of need assessment under subdivision  
27.10 18e. The local agency's financial obligation is limited to funds provided by the state or  
27.11 federal government.
- 27.12 (k) The commissioner shall:
- 27.13 (1) in consultation with the Nonemergency Medical Transportation Advisory Committee,  
27.14 verify that the mode and use of nonemergency medical transportation is appropriate;

- 27.15 (2) verify that the client is going to an approved medical appointment; and
- 27.16 (3) investigate all complaints and appeals.
- 27.17 (1) The administrative agency shall pay for the services provided in this subdivision and  
27.18 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,  
27.19 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary  
27.20 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.
- 27.21 (m) Payments for nonemergency medical transportation must be paid based on the client's  
27.22 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The  
27.23 medical assistance reimbursement rates for nonemergency medical transportation services  
27.24 that are payable by or on behalf of the commissioner for nonemergency medical  
27.25 transportation services are:
- 27.26 (1) \$0.22 per mile for client reimbursement;
- 27.27 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer  
27.28 transport;
- 27.29 (3) equivalent to the standard fare for unassisted transport when provided by public  
27.30 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency  
27.31 medical transportation provider;
- 27.32 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;
- 28.1 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;
- 28.2 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and
- 28.3 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for  
28.4 an additional attendant if deemed medically necessary.
- 28.5 (n) The base rate for nonemergency medical transportation services in areas defined  
28.6 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in  
28.7 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation  
28.8 services in areas defined under RUCA to be rural or super rural areas is:
- 28.9 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage  
28.10 rate in paragraph (m), clauses (1) to (7); and

- 28.11 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage  
28.12 rate in paragraph (m), clauses (1) to (7).
- 28.13 (o) For purposes of reimbursement rates for nonemergency medical transportation  
28.14 services under paragraphs (m) and (n), the zip code of the recipient's place of residence  
28.15 shall determine whether the urban, rural, or super rural reimbursement rate applies.
- 28.16 (p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means  
28.17 a census-tract based classification system under which a geographical area is determined  
28.18 to be urban, rural, or super rural.
- 28.19 (q) The commissioner, when determining reimbursement rates for nonemergency medical  
28.20 transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed  
28.21 under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).
- 28.22 Sec. 18. Minnesota Statutes 2016, section 256B.0625, subdivision 17b, is amended to  
28.23 read:
- 28.24 Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency  
28.25 medical transportation providers must document each occurrence of a service provided to  
28.26 a recipient according to this subdivision. Providers must maintain odometer and other records  
28.27 sufficient to distinguish individual trips with specific vehicles and drivers. The documentation  
28.28 may be collected and maintained using electronic systems or software or in paper form but  
28.29 must be made available and produced upon request. Program funds paid for transportation  
28.30 that is not documented according to this subdivision shall be recovered by the department.
- 28.31 (b) A nonemergency medical transportation provider must compile transportation records  
28.32 that meet the following requirements:
- 29.1 (1) the record must be in English and must be legible according to the standard of a  
29.2 reasonable person;
- 29.3 (2) the recipient's name must be on each page of the record; and
- 29.4 (3) each entry in the record must document:
- 29.5 (i) the date on which the entry is made;
- 29.6 (ii) the date or dates the service is provided;
- 29.7 (iii) the printed last name, first name, and middle initial of the driver;

- 29.8 (iv) the signature of the driver attesting to the following: "I certify that I have accurately  
29.9 reported in this record the trip miles I actually drove and the dates and times I actually drove  
29.10 them. I understand that misreporting the miles driven and hours worked is fraud for which  
29.11 I could face criminal prosecution or civil proceedings.";
- 29.12 (v) the signature of the recipient or authorized party attesting to the following: "I certify  
29.13 that I received the reported transportation service.", or the signature of the provider of  
29.14 medical services certifying that the recipient was delivered to the provider;
- 29.15 (vi) the address, or the description if the address is not available, of both the origin and  
29.16 destination, and the mileage for the most direct route from the origin to the destination;
- 29.17 (vii) the mode of transportation in which the service is provided;
- 29.18 (viii) the license plate number of the vehicle used to transport the recipient;
- 29.19 (ix) whether the service was ambulatory or nonambulatory ~~until the modes under~~  
29.20 ~~subdivision 17 are implemented;~~
- 29.21 (x) the time of the pickup and the time of the drop-off with "a.m." and "p.m."  
29.22 designations;
- 29.23 (xi) the name of the extra attendant when an extra attendant is used to provide special  
29.24 transportation service; and
- 29.25 (xii) the electronic source documentation used to calculate driving directions and mileage.
- 29.26 Sec. 19. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision  
29.27 to read:
- 29.28 Subd. 17c. **Nursing facility transports.** A Minnesota health care program enrollee  
29.29 residing in, or being discharged from, a licensed nursing facility is exempt from a level of  
29.30 need determination and is eligible for nonemergency medical transportation services until  
30.1 the enrollee no longer resides in a licensed nursing facility, as provided in section 256B.04,  
30.2 subdivision 14a.
- 30.3 Sec. 20. Minnesota Statutes 2016, section 256B.0625, subdivision 18h, is amended to  
30.4 read:
- 30.5 Subd. 18h. **Managed care.** (a) The following subdivisions ~~do not~~ apply to managed  
30.6 care plans and county-based purchasing plans:



30.7 ~~(1) subdivision 17, paragraphs (d) to (k) (a), (b), (i), and (n);~~

30.8 ~~(2) subdivision 18e 18;~~ and

30.9 ~~(3) subdivision 18g 18a.~~

30.10 (b) A nonemergency medical transportation provider must comply with the operating  
 30.11 standards for special transportation service specified in sections 174.29 to 174.30 and  
 30.12 Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire  
 30.13 vehicles are exempt from the requirements in this paragraph.

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

### THE FOLLOWING TWO SECTIONS ARE FROM HOUSE ARTICLE 6.

177.11 Sec. 18. Minnesota Statutes 2016, section 256B.0625, subdivision 20, is amended to read:

177.12 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the  
 177.13 state agency, medical assistance covers case management services to persons with serious  
 177.14 and persistent mental illness and children with severe emotional disturbance. Services  
 177.15 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,  
 177.16 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts  
 177.17 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

177.18 (b) Entities meeting program standards set out in rules governing family community  
 177.19 support services as defined in section 245.4871, subdivision 17, are eligible for medical  
 177.20 assistance reimbursement for case management services for children with severe emotional  
 177.21 disturbance when these services meet the program standards in Minnesota Rules, parts  
 177.22 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

177.23 (c) Medical assistance and MinnesotaCare payment for mental health case management  
 177.24 shall be made on a monthly basis. In order to receive payment for an eligible child, the  
 177.25 provider must document at least a face-to-face contact with the child, the child's parents, or  
 177.26 the child's legal representative. To receive payment for an eligible adult, the provider must  
 177.27 document:

177.28 (1) at least a face-to-face contact with the adult or the adult's legal representative or a  
 177.29 contact by interactive video that meets the requirements of subdivision 20b; or

177.30 (2) at least a telephone contact with the adult or the adult's legal representative and  
 177.31 document a face-to-face contact or a contact by interactive video that meets the requirements

274.23 Sec. 14. Minnesota Statutes 2016, section 256B.0625, subdivision 20, is amended to read:

274.24 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the  
 274.25 state agency, medical assistance covers case management services to persons with serious  
 274.26 and persistent mental illness and children with severe emotional disturbance. Services  
 274.27 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,  
 274.28 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts  
 274.29 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

274.30 (b) Entities meeting program standards set out in rules governing family community  
 274.31 support services as defined in section 245.4871, subdivision 17, are eligible for medical  
 275.1 assistance reimbursement for case management services for children with severe emotional  
 275.2 disturbance when these services meet the program standards in Minnesota Rules, parts  
 275.3 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

275.4 (c) Medical assistance and MinnesotaCare payment for mental health case management  
 275.5 shall be made on a monthly basis. In order to receive payment for an eligible child, the  
 275.6 provider must document at least a face-to-face contact with the child, the child's parents, or  
 275.7 the child's legal representative. To receive payment for an eligible adult, the provider must  
 275.8 document:

275.9 (1) at least a face-to-face contact with the adult or the adult's legal representative or a  
 275.10 contact by interactive video that meets the requirements of subdivision 20b; or

275.11 (2) at least a telephone contact with the adult or the adult's legal representative and  
 275.12 document a face-to-face contact or a contact by interactive video that meets the requirements

177.32 of subdivision 20b with the adult or the adult's legal representative within the preceding  
177.33 two months.

178.1 (d) Payment for mental health case management provided by county or state staff shall  
178.2 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph  
178.3 (b), with separate rates calculated for child welfare and mental health, and within mental  
178.4 health, separate rates for children and adults.

178.5 (e) Payment for mental health case management provided by Indian health services or  
178.6 by agencies operated by Indian tribes may be made according to this section or other relevant  
178.7 federally approved rate setting methodology.

178.8 (f) Payment for mental health case management provided by vendors who contract with  
178.9 a county or Indian tribe shall be based on a monthly rate negotiated by the host county or  
178.10 tribe. The negotiated rate must not exceed the rate charged by the vendor for the same  
178.11 service to other payers. If the service is provided by a team of contracted vendors, the county  
178.12 or tribe may negotiate a team rate with a vendor who is a member of the team. The team  
178.13 shall determine how to distribute the rate among its members. No reimbursement received  
178.14 by contracted vendors shall be returned to the county or tribe, except to reimburse the county  
178.15 or tribe for advance funding provided by the county or tribe to the vendor.

178.16 (g) If the service is provided by a team which includes contracted vendors, tribal staff,  
178.17 and county or state staff, the costs for county or state staff participation in the team shall be  
178.18 included in the rate for county-provided services. In this case, the contracted vendor, the  
178.19 tribal agency, and the county may each receive separate payment for services provided by  
178.20 each entity in the same month. In order to prevent duplication of services, each entity must  
178.21 document, in the recipient's file, the need for team case management and a description of  
178.22 the roles of the team members.

178.23 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for  
178.24 mental health case management shall be provided by the recipient's county of responsibility,  
178.25 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds  
178.26 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal  
178.27 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state  
178.28 without a federal share through fee-for-service, 50 percent of the cost shall be provided by  
178.29 the recipient's county of responsibility.

178.30 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance  
178.31 and MinnesotaCare include mental health case management. When the service is provided  
178.32 through prepaid capitation, the nonfederal share is paid by the state and the county pays no  
178.33 share.

275.13 of subdivision 20b with the adult or the adult's legal representative within the preceding  
275.14 two months.

275.15 (d) Payment for mental health case management provided by county or state staff shall  
275.16 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph  
275.17 (b), with separate rates calculated for child welfare and mental health, and within mental  
275.18 health, separate rates for children and adults.

275.19 (e) Payment for mental health case management provided by Indian health services or  
275.20 by agencies operated by Indian tribes may be made according to this section or other relevant  
275.21 federally approved rate setting methodology.

275.22 (f) Payment for mental health case management provided by vendors who contract with  
275.23 a county or Indian tribe shall be based on a monthly rate negotiated by the host county or  
275.24 tribe. The negotiated rate must not exceed the rate charged by the vendor for the same  
275.25 service to other payers. If the service is provided by a team of contracted vendors, the county  
275.26 or tribe may negotiate a team rate with a vendor who is a member of the team. The team  
275.27 shall determine how to distribute the rate among its members. No reimbursement received  
275.28 by contracted vendors shall be returned to the county or tribe, except to reimburse the county  
275.29 or tribe for advance funding provided by the county or tribe to the vendor.

275.30 (g) If the service is provided by a team which includes contracted vendors, tribal staff,  
275.31 and county or state staff, the costs for county or state staff participation in the team shall be  
275.32 included in the rate for county-provided services. In this case, the contracted vendor, the  
275.33 tribal agency, and the county may each receive separate payment for services provided by  
275.34 each entity in the same month. In order to prevent duplication of services, each entity must  
276.1 document, in the recipient's file, the need for team case management and a description of  
276.2 the roles of the team members.

276.3 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for  
276.4 mental health case management shall be provided by the recipient's county of responsibility,  
276.5 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds  
276.6 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal  
276.7 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state  
276.8 without a federal share through fee-for-service, 50 percent of the cost shall be provided by  
276.9 the recipient's county of responsibility.

276.10 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance  
276.11 and MinnesotaCare include mental health case management. When the service is provided  
276.12 through prepaid capitation, the nonfederal share is paid by the state and the county pays no  
276.13 share.

179.1 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider  
 179.2 that does not meet the reporting or other requirements of this section. The county of  
 179.3 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,  
 179.4 is responsible for any federal disallowances. The county or tribe may share this responsibility  
 179.5 with its contracted vendors.

179.6 (k) The commissioner shall set aside a portion of the federal funds earned for county  
 179.7 expenditures under this section to repay the special revenue maximization account under  
 179.8 section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

179.9 (1) the costs of developing and implementing this section; and

179.10 (2) programming the information systems.

179.11 (l) Payments to counties and tribal agencies for case management expenditures under  
 179.12 this section shall only be made from federal earnings from services provided under this  
 179.13 section. When this service is paid by the state without a federal share through fee-for-service,  
 179.14 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors  
 179.15 shall include the federal earnings, the state share, and the county share.

179.16 (m) Case management services under this subdivision do not include therapy, treatment,  
 179.17 legal, or outreach services.

179.18 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,  
 179.19 and the recipient's institutional care is paid by medical assistance, payment for case  
 179.20 management services under this subdivision is limited to the lesser of:

179.21 (1) the last 180 days of the recipient's residency in that facility and may not exceed more  
 179.22 than six months in a calendar year; or

179.23 (2) the limits and conditions which apply to federal Medicaid funding for this service.

179.24 (o) Payment for case management services under this subdivision shall not duplicate  
 179.25 payments made under other program authorities for the same purpose.

179.26 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting  
 179.27 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,  
 179.28 mental health targeted case management services must actively support identification of  
 179.29 community alternatives for the recipient and discharge planning.

179.30 **EFFECTIVE DATE.** This section is effective three months after federal approval.

276.14 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider  
 276.15 that does not meet the reporting or other requirements of this section. The county of  
 276.16 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,  
 276.17 is responsible for any federal disallowances. The county or tribe may share this responsibility  
 276.18 with its contracted vendors.

276.19 (k) The commissioner shall set aside a portion of the federal funds earned for county  
 276.20 expenditures under this section to repay the special revenue maximization account under  
 276.21 section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

276.22 (1) the costs of developing and implementing this section; and

276.23 (2) programming the information systems.

276.24 (l) Payments to counties and tribal agencies for case management expenditures under  
 276.25 this section shall only be made from federal earnings from services provided under this  
 276.26 section. When this service is paid by the state without a federal share through fee-for-service,  
 276.27 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors  
 276.28 shall include the federal earnings, the state share, and the county share.

276.29 (m) Case management services under this subdivision do not include therapy, treatment,  
 276.30 legal, or outreach services.

276.31 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,  
 276.32 and the recipient's institutional care is paid by medical assistance, payment for case  
 276.33 management services under this subdivision is limited to the lesser of:

277.1 (1) the last 180 days of the recipient's residency in that facility and may not exceed more  
 277.2 than six months in a calendar year; or

277.3 (2) the limits and conditions which apply to federal Medicaid funding for this service.

277.4 (o) Payment for case management services under this subdivision shall not duplicate  
 277.5 payments made under other program authorities for the same purpose.

277.6 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting  
 277.7 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,  
 277.8 mental health targeted case management services must actively support identification of  
 277.9 community alternatives for the recipient and discharge planning.

180.1 Sec. 19. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision  
 180.2 to read:

180.3 Subd. 20b. **Mental health targeted case management through interactive video.** (a)  
 180.4 Subject to federal approval, contact made for targeted case management by interactive video  
 180.5 shall be eligible for payment if:

180.6 (1) the person receiving targeted case management services is residing in:

180.7 (i) a hospital;

180.8 (ii) a nursing facility; or

180.9 (iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging  
 180.10 establishment or lodging establishment that provides supportive services or health supervision  
 180.11 services according to section 157.17 that is staffed 24 hours a day, seven days a week;

180.12 (2) interactive video is in the best interests of the person and is deemed appropriate by  
 180.13 the person receiving targeted case management or the person's legal guardian, the case  
 180.14 management provider, and the provider operating the setting where the person is residing;

180.15 (3) the use of interactive video is approved as part of the person's written personal service  
 180.16 or case plan, taking into consideration the person's vulnerability and active personal  
 180.17 relationships; and

180.18 (4) interactive video is used for up to, but not more than, 50 percent of the minimum  
 180.19 required face-to-face contact.

180.20 (b) The person receiving targeted case management or the person's legal guardian has  
 180.21 the right to choose and consent to the use of interactive video under this subdivision and  
 180.22 has the right to refuse the use of interactive video at any time.

180.23 (c) The commissioner shall establish criteria that a targeted case management provider  
 180.24 must attest to in order to demonstrate the safety or efficacy of delivering the service via  
 180.25 interactive video. The attestation may include that the case management provider has:

180.26 (1) written policies and procedures specific to interactive video services that are regularly  
 180.27 reviewed and updated;

180.28 (2) policies and procedures that adequately address client safety before, during, and after  
 180.29 the interactive video services are rendered;

277.10 Sec. 15. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision  
 277.11 to read:

277.12 Subd. 20b. **Mental health targeted case management through interactive video.** (a)  
 277.13 Subject to federal approval, contact made for targeted case management by interactive video  
 277.14 shall be eligible for payment if:

277.15 (1) the person receiving targeted case management services is residing in:

277.16 (i) a hospital;

277.17 (ii) a nursing facility; or

277.18 (iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging  
 277.19 establishment or lodging establishment that provides supportive services or health supervision  
 277.20 services according to section 157.17 that is staffed 24 hours a day, seven days a week;

277.21 (2) interactive video is in the best interests of the person and is deemed appropriate by  
 277.22 the person receiving targeted case management or the person's legal guardian, the case  
 277.23 management provider, and the provider operating the setting where the person is residing;

277.24 (3) the use of interactive video is approved as part of the person's written personal service  
 277.25 or case plan, taking into consideration the person's vulnerability and active personal  
 277.26 relationships; and

277.27 (4) interactive video is used for up to, but not more than, 50 percent of the minimum  
 277.28 required face-to-face contact.

277.29 (b) The person receiving targeted case management or the person's legal guardian has  
 277.30 the right to choose and consent to the use of interactive video under this subdivision and  
 277.31 has the right to refuse the use of interactive video at any time.

278.1 (c) The commissioner shall establish criteria that a targeted case management provider  
 278.2 must attest to in order to demonstrate the safety or efficacy of delivering the service via  
 278.3 interactive video. The attestation may include that the case management provider has:

278.4 (1) written policies and procedures specific to interactive video services that are regularly  
 278.5 reviewed and updated;

278.6 (2) policies and procedures that adequately address client safety before, during, and after  
 278.7 the interactive video services are rendered;

- 180.30 (3) established protocols addressing how and when to discontinue interactive video  
 180.31 services; and
- 181.1 (4) established a quality assurance process related to interactive video services.
- 181.2 (d) As a condition of payment, the targeted case management provider must document  
 181.3 the following for each occurrence of targeted case management provided by interactive  
 181.4 video:
- 181.5 (1) the time the service began and the time the service ended, including an a.m. and p.m.  
 181.6 designation;
- 181.7 (2) the basis for determining that interactive video is an appropriate and effective means  
 181.8 for delivering the service to the person receiving case management services;
- 181.9 (3) the mode of transmission of the interactive video services and records evidencing  
 181.10 that a particular mode of transmission was utilized;
- 181.11 (4) the location of the originating site and the distant site; and
- 181.12 (5) compliance with the criteria attested to by the targeted case management provider  
 181.13 as provided in paragraph (c).
- 181.14 **EFFECTIVE DATE.** This section is effective three months after federal approval.

- 278.8 (3) established protocols addressing how and when to discontinue interactive video  
 278.9 services; and
- 278.10 (4) established a quality assurance process related to interactive video services.
- 278.11 (d) As a condition of payment, the targeted case management provider must document  
 278.12 the following for each occurrence of targeted case management provided by interactive  
 278.13 video:
- 278.14 (1) the time the service began and the time the service ended, including an a.m. and p.m.  
 278.15 designation;
- 278.16 (2) the basis for determining that interactive video is an appropriate and effective means  
 278.17 for delivering the service to the person receiving case management services;
- 278.18 (3) the mode of transmission of the interactive video services and records evidencing  
 278.19 that a particular mode of transmission was utilized;
- 278.20 (4) the location of the originating site and the distant site; and
- 278.21 (5) compliance with the criteria attested to by the targeted case management provider  
 278.22 as provided in paragraph (c).

### THE FOLLOWING SECTIONS ARE FROM HOUSE ARTICLE 1.

- 30.15 Sec. 21. Minnesota Statutes 2016, section 256B.0625, subdivision 30, is amended to read:
- 30.16 Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services,  
 30.17 federally qualified health center services, nonprofit community health clinic services, and  
 30.18 public health clinic services. Rural health clinic services and federally qualified health center  
 30.19 services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and  
 30.20 (C). Payment for rural health clinic and federally qualified health center services shall be  
 30.21 made according to applicable federal law and regulation.
- 30.22 (b) A federally qualified health center (FQHC) that is beginning initial operation shall  
 30.23 submit an estimate of budgeted costs and visits for the initial reporting period in the form  
 30.24 and detail required by the commissioner. A federally qualified health center An FQHC that  
 30.25 is already in operation shall submit an initial report using actual costs and visits for the

30.26 initial reporting period. Within 90 days of the end of its reporting period, a ~~federally qualified~~  
 30.27 ~~health center~~ an FQHC shall submit, in the form and detail required by the commissioner,  
 30.28 a report of its operations, including allowable costs actually incurred for the period and the  
 30.29 actual number of visits for services furnished during the period, and other information  
 30.30 required by the commissioner. ~~Federally qualified health centers~~ FQHCs that file Medicare  
 30.31 cost reports shall provide the commissioner with a copy of the most recent Medicare cost  
 31.1 report filed with the Medicare program intermediary for the reporting year which support  
 31.2 the costs claimed on their cost report to the state.

31.3 (c) In order to continue cost-based payment under the medical assistance program  
 31.4 according to paragraphs (a) and (b), ~~a federally qualified health center~~ an FQHC or rural  
 31.5 health clinic must apply for designation as an essential community provider within six  
 31.6 months of final adoption of rules by the Department of Health according to section 62Q.19,  
 31.7 subdivision 7. For those ~~federally qualified health centers~~ FQHCs and rural health clinics  
 31.8 that have applied for essential community provider status within the six-month time  
 31.9 prescribed, medical assistance payments will continue to be made according to paragraphs  
 31.10 (a) and (b) for the first three years after application. For ~~federally qualified health centers~~  
 31.11 FQHCs and rural health clinics that either do not apply within the time specified above or  
 31.12 who have had essential community provider status for three years, medical assistance  
 31.13 payments for health services provided by these entities shall be according to the same rates  
 31.14 and conditions applicable to the same service provided by health care providers that are not  
 31.15 ~~federally qualified health centers~~ FQHCs or rural health clinics.

31.16 (d) Effective July 1, 1999, the provisions of paragraph (c) requiring ~~a federally qualified~~  
 31.17 ~~health center~~ an FQHC or a rural health clinic to make application for an essential community  
 31.18 provider designation in order to have cost-based payments made according to paragraphs  
 31.19 (a) and (b) no longer apply.

31.20 (e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall  
 31.21 be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

31.22 (f) Effective January 1, 2001, through December 31, 2018, each ~~federally qualified~~  
 31.23 ~~health center~~ FQHC and rural health clinic may elect to be paid either under the prospective  
 31.24 payment system established in United States Code, title 42, section 1396a(aa), or under an  
 31.25 alternative payment methodology consistent with the requirements of United States Code,  
 31.26 title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services.  
 31.27 The alternative payment methodology shall be 100 percent of cost as determined according  
 31.28 to Medicare cost principles.

31.29 (g) Effective for services provided on or after January 1, 2019, all claims for payment  
 31.30 of clinic services provided by FQHCs and rural health clinics shall be paid by the  
 31.31 commissioner, according to an annual election by the FQHC or rural health clinic, under  
 31.32 the current prospective payment system described in paragraph (f), the alternative payment

- 31.33 methodology described in paragraph (f), or the alternative payment methodology described  
 31.34 in paragraph (l).
- 32.1 ~~(g)~~ (h) For purposes of this section, "nonprofit community clinic" is a clinic that:
- 32.2 (1) has nonprofit status as specified in chapter 317A;
- 32.3 (2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);
- 32.4 (3) is established to provide health services to low-income population groups, uninsured,  
 32.5 high-risk and special needs populations, underserved and other special needs populations;
- 32.6 (4) employs professional staff at least one-half of which are familiar with the cultural  
 32.7 background of their clients;
- 32.8 (5) charges for services on a sliding fee scale designed to provide assistance to  
 32.9 low-income clients based on current poverty income guidelines and family size; and
- 32.10 (6) does not restrict access or services because of a client's financial limitations or public  
 32.11 assistance status and provides no-cost care as needed.
- 32.12 ~~(h)~~ (i) Effective for services provided on or after January 1, 2015, all claims for payment  
 32.13 of clinic services provided by ~~federally qualified health centers~~ FQHCs and rural health  
 32.14 clinics shall be paid by the commissioner. Effective for services provided on or after January  
 32.15 1, 2015, through July 1, 2017, the commissioner shall determine the most feasible method  
 32.16 for paying claims from the following options:
- 32.17 (1) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims  
 32.18 directly to the commissioner for payment, and the commissioner provides claims information  
 32.19 for recipients enrolled in a managed care or county-based purchasing plan to the plan, on  
 32.20 a regular basis; or
- 32.21 (2) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims for  
 32.22 recipients enrolled in a managed care or county-based purchasing plan to the plan, and those  
 32.23 claims are submitted by the plan to the commissioner for payment to the clinic.
- 32.24 Effective for services provided on or after January 1, 2019, FQHCs and rural health clinics  
 32.25 shall submit claims directly to the commissioner for payment and the commissioner shall  
 32.26 provide claims information for recipients enrolled in a managed care plan or county-based  
 32.27 purchasing plan to the plan on a regular basis to be determined by the commissioner.

32.28 ~~(j)~~ (i) For clinic services provided prior to January 1, 2015, the commissioner shall  
 32.29 calculate and pay monthly the proposed managed care supplemental payments to clinics,  
 32.30 and clinics shall conduct a timely review of the payment calculation data in order to finalize  
 32.31 all supplemental payments in accordance with federal law. Any issues arising from a clinic's  
 32.32 review must be reported to the commissioner by January 1, 2017. Upon final agreement  
 33.1 between the commissioner and a clinic on issues identified under this subdivision, and in  
 33.2 accordance with United States Code, title 42, section 1396a(bb), no supplemental payments  
 33.3 for managed care plan or county-based purchasing plan claims for services provided prior  
 33.4 to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are  
 33.5 unable to resolve issues under this subdivision, the parties shall submit the dispute to the  
 33.6 arbitration process under section 14.57.

33.7 ~~(k)~~ (k) The commissioner shall seek a federal waiver, authorized under section 1115 of  
 33.8 the Social Security Act, to obtain federal financial participation at the 100 percent federal  
 33.9 matching percentage available to facilities of the Indian Health Service or tribal organization  
 33.10 in accordance with section 1905(b) of the Social Security Act for expenditures made to  
 33.11 organizations dually certified under Title V of the Indian Health Care Improvement Act,  
 33.12 Public Law 94-437, and as a ~~federally-qualified health center~~ FQHC under paragraph (a)  
 33.13 that provides services to American Indian and Alaskan Native individuals eligible for  
 33.14 services under this subdivision.

33.15 (l) Effective for services provided on or after January 1, 2019, all claims for payment  
 33.16 of clinic services provided by FQHCs and rural health clinics shall be paid by the  
 33.17 commissioner according to the current prospective payment system described in paragraph  
 33.18 (f), or an alternative payment methodology with the following requirements:

33.19 (1) each FQHC and rural health clinic must receive a single medical and a single dental  
 33.20 organization rate;

33.21 (2) the commissioner shall reimburse FQHCs and rural health clinics for allowable costs,  
 33.22 including direct patient care costs and patient-related support services, based upon Medicare  
 33.23 cost principles that apply at the time the alternative payment methodology is calculated;

33.24 (3) the 2019 payment rates for FQHCs and rural health clinics:

33.25 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports  
 33.26 from 2015 and 2016. A provider must submit the required cost reports to the commissioner  
 33.27 within six months of the second base year calendar or fiscal year end. Cost reports must be  
 33.28 submitted six months before the quarter in which the base rate will take effect;

33.29 (ii) must be according to current Medicare cost principles applicable to FQHCs and rural  
 33.30 health clinics at the time of the alternative payment rate calculation without the application



- 33.31 of productivity screens and upper payment limits or the Medicare prospective payment  
33.32 system FQHC aggregate mean upper payment limit; and
- 33.33 (iii) must provide for a 60-day appeals process;
- 34.1 (4) the commissioner shall inflate the base year payment rate for FQHCs and rural health  
34.2 clinics to the effective date by using the Bureau of Economic Analysis's personal consumption  
34.3 expenditures medical care inflator;
- 34.4 (5) the commissioner shall establish a statewide trend inflator using 2015-2020 costs  
34.5 replacing the use of the personal consumption expenditures medical care inflator with the  
34.6 2023 rate calculation forward;
- 34.7 (6) FQHC and rural health clinic payment rates shall be rebased by the commissioner  
34.8 every two years using the methodology described in clause (3), using the provider's Medicare  
34.9 cost reports from the previous third and fourth years. In nonrebasng years, the commissioner  
34.10 shall adjust using the Medicare economic index until 2023 when the statewide trend inflator  
34.11 is available;
- 34.12 (7) the commissioner shall increase payments by two percent according to Laws 2003,  
34.13 First Special Session chapter 14, article 13C, section 2, subdivision 6. This is an add-on to  
34.14 the rate and must not be included in the base rate calculation;
- 34.15 (8) for FQHCs and rural health clinics seeking a change of scope of services:
- 34.16 (i) the commissioner shall require FQHCs and rural health clinics to submit requests to  
34.17 the commissioner, if the change of scope would result in the medical or dental payment rate  
34.18 currently received by the FQHC or rural health clinic increasing or decreasing by at least  
34.19 2-1/2 percent;
- 34.20 (ii) FQHCs and rural health clinics shall submit the request to the commissioner within  
34.21 seven business days of submission of the scope change to the federal Health Resources  
34.22 Services Administration;
- 34.23 (iii) the effective date of the payment change is the date the Health Resources Services  
34.24 Administration approves the FQHC's or rural health clinic's change of scope request;
- 34.25 (iv) for change of scope requests that do not require Health Resources Services  
34.26 Administration approval, FQHCs and rural health clinics shall submit the request to the  
34.27 commissioner before implementing the change, and the effective date of the change is the  
34.28 date the commissioner receives the request from the FQHC or rural health clinic; and

34.29 (v) the commissioner shall provide a response to the FQHC's or rural health clinic's  
 34.30 change of scope request within 45 days of submission and provide a final decision regarding  
 34.31 approval or disapproval within 120 days of submission. If more information is needed to  
 34.32 evaluate the request, this timeline may be waived by mutual agreement of the commissioner  
 34.33 and the FQHC or rural health clinic; and

35.1 (9) the commissioner shall establish a payment rate for new FQHC and rural health  
 35.2 clinic organizations, considering the following factors:

35.3 (i) a comparison of patient caseload of FQHCs and rural health clinics within a 60-mile  
 35.4 radius for organizations established outside the seven-county metropolitan area and within  
 35.5 a 30-mile radius for organizations within the seven-county metropolitan area; and

35.6 (ii) if a comparison is not feasible under item (i), the commissioner may use Medicare  
 35.7 cost reports or audited financial statements to establish the base rate.

#### HOUSE ART. 1, SEC. 22 - SEE SENATE ART. 8, SEC. 59

181.15 Sec. 20. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision  
 181.16 to read:

181.17 Subd. 56a. **Post-arrest community-based service coordination.** (a) Medical assistance  
 181.18 covers post-arrest community-based service coordination for an individual who:

181.19 (1) has been identified as having a mental illness or substance use disorder using a  
 181.20 screening tool approved by the commissioner;

181.21 (2) does not require the security of a public detention facility and is not considered an  
 181.22 inmate of a public institution as defined in Code of Federal Regulations, title 42, section  
 181.23 435.1010;

181.24 (3) meets the eligibility requirements in section 256B.056; and

181.25 (4) has agreed to participate in post-arrest community-based service coordination through  
 181.26 a diversion contract in lieu of incarceration.

181.27 (b) Post-arrest community-based service coordination means navigating services to  
 181.28 address a client's mental health, chemical health, social, economic, and housing needs, or  
 181.29 any other activity targeted at reducing the incidence of jail utilization and connecting  
 181.30 individuals with existing covered services available to them, including, but not limited to,  
 181.31 targeted case management, waiver case management, or care coordination.

- 182.1 (c) Post-arrest community-based service coordination must be provided by individuals  
182.2 who are qualified under one of the following criteria:
- 182.3 (1) a licensed mental health professional as defined in section 245.462, subdivision 18,  
182.4 clauses (1) to (6);
- 182.5 (2) a mental health practitioner as defined in section 245.462, subdivision 17, working  
182.6 under the clinical supervision of a mental health professional; or
- 182.7 (3) a certified peer specialist under section 256B.0615, working under the clinical  
182.8 supervision of a mental health professional.
- 182.9 (d) Reimbursement must be made in 15-minute increments and allowed for up to 60  
182.10 days following the initial determination of eligibility.
- 182.11 (e) Providers of post-arrest community-based service coordination shall annually report  
182.12 to the commissioner on the number of individuals served, and number of the  
182.13 community-based services that were accessed by recipients. The commissioner shall ensure  
182.14 that services and payments provided under post-arrest community-based service coordination  
182.15 do not duplicate services or payments provided under section 256B.0625, subdivision 20,  
182.16 256B.0753, 256B.0755, or 256B.0757.
- 182.17 (f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for  
182.18 post-arrest community-based service coordination services shall be provided by the recipient's  
182.19 county of residence, from sources other than federal funds or funds used to match other  
182.20 federal funds.
- 182.21 **EFFECTIVE DATE.** This section is effective three months after federal approval.
- 182.22 Sec. 21. Minnesota Statutes 2016, section 256B.0625, subdivision 57, is amended to read:
- 182.23 **Subd. 57. Payment for Part B Medicare crossover claims.** (a) Effective for services  
182.24 provided on or after January 1, 2012, medical assistance payment for an enrollee's  
182.25 cost-sharing associated with Medicare Part B is limited to an amount up to the medical  
182.26 assistance total allowed, when the medical assistance rate exceeds the amount paid by  
182.27 Medicare.
- 182.28 (b) Excluded from this limitation are payments for mental health services and payments  
182.29 for dialysis services provided to end-stage renal disease patients. The exclusion for mental  
182.30 health services does not apply to payments for physician services provided by psychiatrists  
182.31 and advanced practice nurses with a specialty in mental health.

183.1 (c) Excluded from this limitation are payments to federally qualified health centers,  
183.2 Indian Health Services, and rural health clinics.

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

35.26 Sec. 23. Minnesota Statutes 2016, section 256B.0625, subdivision 60a, is amended to  
35.27 read:

35.28 Subd. 60a. **Community medical response emergency medical technician services.**  
35.29 (a) Medical assistance covers services provided by a community medical response emergency  
35.30 medical technician (CEMT) who is certified under section 144E.275, subdivision 7, when  
35.31 the services are provided in accordance with this subdivision.

36.1 (b) A CEMT may provide a ~~posthospital discharge~~ postdischarge visit, after discharge  
36.2 from a hospital or skilled nursing facility, when ordered by a treating physician. The  
36.3 ~~posthospital discharge~~ postdischarge visit includes:

- 36.4 (1) verbal or visual reminders of discharge orders;
- 36.5 (2) recording and reporting of vital signs to the patient's primary care provider;
- 36.6 (3) medication access confirmation;
- 36.7 (4) food access confirmation; and
- 36.8 (5) identification of home hazards.

36.9 (c) ~~An individual who has repeat ambulance calls due to falls, has been discharged from~~  
36.10 ~~a nursing home,~~ or has been identified by the individual's primary care provider as at risk  
36.11 for nursing home placement, may receive a safety evaluation visit from a CEMT when  
36.12 ordered by a primary care provider in accordance with the individual's care plan. A safety  
36.13 evaluation visit includes:

- 36.14 (1) medication access confirmation;
- 36.15 (2) food access confirmation; and
- 36.16 (3) identification of home hazards.

183.4 Sec. 22. Minnesota Statutes 2016, section 256B.0625, subdivision 64, is amended to read:

183.5 Subd. 64. **Investigational drugs, biological products, and devices.** (a) Medical  
183.6 assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do  
183.7 not cover costs incidental to, associated with, or resulting from the use of investigational  
183.8 drugs, biological products, or devices as defined in section 151.375.

183.9 (b) Notwithstanding paragraph (a), stiripentol may be covered by the EPSDT program  
183.10 if all the following conditions are met:

183.11 (1) the use of stiripentol is determined to be medically necessary;

183.12 (2) the enrollee has a documented diagnosis of Dravet syndrome, regardless of whether  
183.13 an SCN1A genetic mutation is found, or the enrollee is a child with malignant migrating  
183.14 partial epilepsy in infancy due to an SCN2A genetic mutation;

183.15 (3) all other available covered prescription medications that are medically necessary for  
183.16 the enrollee have been tried without successful outcomes; and

183.17 (4) the United States Food and Drug Administration has approved the treating physician's  
183.18 individual patient investigational new drug application (IND) for the use of stiripentol for  
183.19 treatment.

183.20 This paragraph does not apply to MinnesotaCare coverage under chapter 256L.

36.17 (d) A CEMT shall be paid at \$9.75 per 15-minute increment. A safety evaluation visit  
36.18 may not be billed for the same day as a posthospital discharge postdischarge visit for the  
36.19 same individual.

36.20 Sec. 24. Minnesota Statutes 2016, section 256B.0625, subdivision 64, is amended to read:

36.21 Subd. 64. **Investigational drugs, biological products, and devices.** Medical assistance  
36.22 and the early periodic screening, diagnosis, and treatment (EPSDT) program do not cover  
36.23 costs incidental to, associated with, or resulting from the use of investigational drugs,  
36.24 biological products, or devices as defined in section 151.375; except that stiripentol may  
36.25 be covered by the EPSDT program, only if all of the following conditions are met:

36.26 (1) the use of stiripentol is determined to be medically necessary;

36.27 (2) stiripentol is covered only for eligible enrollees with a documented diagnosis of  
36.28 Dravet syndrome, regardless of whether an SCN1A genetic mutation is found, or children  
36.29 with Malignant Migrating Partial Epilepsy in Infancy due to an SCN2A genetic mutation;

36.30 (3) all other available covered prescription medications that are medically necessary for  
36.31 the patient have been tried without successful outcomes; and

37.1 (4) the United States Food and Drug Administration has approved the treating physician's  
37.2 individual patient investigational new drug application (IND) for the use of stiripentol for  
37.3 treatment.

37.4 This provision related to coverage of stiripentol does not apply to MinnesotaCare  
37.5 coverage under chapter 256L.

37.6 Sec. 25. Minnesota Statutes 2016, section 256B.0644, is amended to read:

37.7 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**  
37.8 **PROGRAMS.**

37.9 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health  
37.10 maintenance organization, as defined in chapter 62D, must participate as a provider or  
37.11 contractor in the medical assistance program and MinnesotaCare as a condition of  
37.12 participating as a provider in health insurance plans and programs or contractor for state  
37.13 employees established under section 43A.18, the public employees insurance program under  
37.14 section 43A.316, for health insurance plans offered to local statutory or home rule charter  
37.15 city, county, and school district employees, the workers' compensation system under section  
37.16 176.135, and insurance plans provided through the Minnesota Comprehensive Health

37.17 Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to  
37.18 local government employees shall not be applicable in geographic areas where provider  
37.19 participation is limited by managed care contracts with the Department of Human Services.  
37.20 This section does not apply to dental service providers providing dental services outside  
37.21 the seven-county metropolitan area.

37.22 (b) For providers other than health maintenance organizations, participation in the medical  
37.23 assistance program means that:

37.24 (1) the provider accepts new medical assistance and MinnesotaCare patients;

37.25 (2) for providers other than dental service providers, at least 20 percent of the provider's  
37.26 patients are covered by medical assistance and MinnesotaCare as their primary source of  
37.27 coverage; or

37.28 (3) for dental service providers providing dental services in the seven-county metropolitan  
37.29 area, at least ten percent of the provider's patients are covered by medical assistance and  
37.30 MinnesotaCare as their primary source of coverage, or the provider accepts new medical  
37.31 assistance and MinnesotaCare patients who are children with special health care needs. For  
37.32 purposes of this section, "children with special health care needs" means children up to age  
37.33 18 who: (i) require health and related services beyond that required by children generally;  
38.1 and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional  
38.2 condition, including: bleeding and coagulation disorders; immunodeficiency disorders;  
38.3 cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other  
38.4 neurological diseases; visual impairment or deafness; Down syndrome and other genetic  
38.5 disorders; autism; fetal alcohol syndrome; and other conditions designated by the  
38.6 commissioner after consultation with representatives of pediatric dental providers and  
38.7 consumers.

38.8 (c) Patients seen on a volunteer basis by the provider at a location other than the provider's  
38.9 usual place of practice may be considered in meeting the participation requirement in this  
38.10 section. The commissioner shall establish participation requirements for health maintenance  
38.11 organizations. The commissioner shall provide lists of participating medical assistance  
38.12 providers on a quarterly basis to the commissioner of management and budget, the  
38.13 commissioner of labor and industry, and the commissioner of commerce. Each of the  
38.14 commissioners shall develop and implement procedures to exclude as participating providers  
38.15 in the program or programs under their jurisdiction those providers who do not participate  
38.16 in the medical assistance program. The commissioner of management and budget shall  
38.17 implement this section through contracts with participating health and dental carriers.

183.21 Sec. 23. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

183.22 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**

183.23 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of  
183.24 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in  
183.25 a format determined by the commissioner, information and documentation that includes,  
183.26 but is not limited to, the following:

183.27 (1) the personal care assistance provider agency's current contact information including  
183.28 address, telephone number, and e-mail address;

183.29 (2) proof of surety bond coverage for each location providing services. Upon new  
183.30 enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and  
183.31 including \$300,000, the provider agency must purchase a surety bond of \$50,000. If the  
184.1 Medicaid revenue in the previous year is over \$300,000, the provider agency must purchase  
184.2 a surety bond of \$100,000. The surety bond must be in a form approved by the commissioner,  
184.3 must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim  
184.4 on the bond;

184.5 (3) proof of fidelity bond coverage in the amount of \$20,000 for each business location  
184.6 providing service;

184.7 (4) proof of workers' compensation insurance coverage identifying the business address  
184.8 where PCA services are provided from;

184.9 (5) proof of liability insurance coverage identifying the business address where PCA  
184.10 services are provided from and naming the department as a certificate holder;

184.11 (6) a description of the personal care assistance provider agency's organization identifying  
184.12 the names of all owners, managing employees, staff, board of directors, and the affiliations  
184.13 of the directors, owners, or staff to other service providers;

38.18 (d) A volunteer dentist who has signed a volunteer agreement under section 256B.0625,  
38.19 subdivision 9a, shall not be considered to be participating in medical assistance or  
38.20 MinnesotaCare for the purpose of this section.

38.21 **EFFECTIVE DATE.** This section is effective upon receipt of any necessary federal  
38.22 waiver or approval. The commissioner of human services shall notify the revisor of statutes  
38.23 if a federal waiver or approval is sought and, if sought, when a federal waiver or approval  
38.24 is obtained.

184.14 ~~(7)~~ (6) a copy of the personal care assistance provider agency's written policies and  
184.15 procedures including: hiring of employees; training requirements; service delivery; and  
184.16 employee and consumer safety including process for notification and resolution of consumer  
184.17 grievances, identification and prevention of communicable diseases, and employee  
184.18 misconduct;

184.19 ~~(8)~~ (7) copies of all other forms the personal care assistance provider agency uses in the  
184.20 course of daily business including, but not limited to:

184.21 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet  
184.22 varies from the standard time sheet for personal care assistance services approved by the  
184.23 commissioner, and a letter requesting approval of the personal care assistance provider  
184.24 agency's nonstandard time sheet;

184.25 (ii) the personal care assistance provider agency's template for the personal care assistance  
184.26 care plan; and

184.27 (iii) the personal care assistance provider agency's template for the written agreement  
184.28 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

184.29 ~~(9)~~ (8) a list of all training and classes that the personal care assistance provider agency  
184.30 requires of its staff providing personal care assistance services;

184.31 ~~(10)~~ (9) documentation that the personal care assistance provider agency and staff have  
184.32 successfully completed all the training required by this section;

185.1 ~~(11)~~ (10) documentation of the agency's marketing practices;

185.2 ~~(12)~~ (11) disclosure of ownership, leasing, or management of all residential properties  
185.3 that is used or could be used for providing home care services;

185.4 ~~(13)~~ (12) documentation that the agency will use the following percentages of revenue  
185.5 generated from the medical assistance rate paid for personal care assistance services for  
185.6 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal  
185.7 care assistance choice option and 72.5 percent of revenue from other personal care assistance  
185.8 providers. The revenue generated by the qualified professional and the reasonable costs  
185.9 associated with the qualified professional shall not be used in making this calculation; and

185.10 ~~(14)~~ (13) effective May 15, 2010, documentation that the agency does not burden  
185.11 recipients' free exercise of their right to choose service providers by requiring personal care  
185.12 assistants to sign an agreement not to work with any particular personal care assistance  
185.13 recipient or for another personal care assistance provider agency after leaving the agency



185.14 and that the agency is not taking action on any such agreements or requirements regardless  
185.15 of the date signed.

185.16 (b) Personal care assistance provider agencies shall provide the information specified  
185.17 in paragraph (a) to the commissioner at the time the personal care assistance provider agency  
185.18 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect  
185.19 the information specified in paragraph (a) from all personal care assistance providers  
185.20 beginning July 1, 2009.

185.21 (c) All personal care assistance provider agencies shall require all employees in  
185.22 management and supervisory positions and owners of the agency who are active in the  
185.23 day-to-day management and operations of the agency to complete mandatory training as  
185.24 determined by the commissioner before submitting an application for enrollment of the  
185.25 agency as a provider. All personal care assistance provider agencies shall also require  
185.26 qualified professionals to complete the training required by subdivision 13 before submitting  
185.27 an application for enrollment of the agency as a provider. Employees in management and  
185.28 supervisory positions and owners who are active in the day-to-day operations of an agency  
185.29 who have completed the required training as an employee with a personal care assistance  
185.30 provider agency do not need to repeat the required training if they are hired by another  
185.31 agency, if they have completed the training within the past three years. By September 1,  
185.32 2010, the required training must be available with meaningful access according to title VI  
185.33 of the Civil Rights Act and federal regulations adopted under that law or any guidance from  
185.34 the United States Health and Human Services Department. The required training must be  
186.1 available online or by electronic remote connection. The required training must provide for  
186.2 competency testing. Personal care assistance provider agency billing staff shall complete  
186.3 training about personal care assistance program financial management. This training is  
186.4 effective July 1, 2009. Any personal care assistance provider agency enrolled before that  
186.5 date shall, if it has not already, complete the provider training within 18 months of July 1,  
186.6 2009. Any new owners or employees in management and supervisory positions involved  
186.7 in the day-to-day operations are required to complete mandatory training as a requisite of  
186.8 working for the agency. Personal care assistance provider agencies certified for participation  
186.9 in Medicare as home health agencies are exempt from the training required in this  
186.10 subdivision. When available, Medicare-certified home health agency owners, supervisors,  
186.11 or managers must successfully complete the competency test.

186.12 (d) All surety bonds, fidelity bonds, workers' compensation insurance, and liability  
186.13 insurance required by this subdivision must be maintained continuously. After initial  
186.14 enrollment, a provider must submit proof of bonds and required coverages at any time at  
186.15 the request of the commissioner. Services provided while there are lapses in coverage are  
186.16 not eligible for payment. Lapses in coverage may result in sanctions, including termination.  
186.17 The commissioner shall send instructions and a due date to submit the requested information  
186.18 to the personal care assistance provider agency.

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

186.20 Sec. 24. Minnesota Statutes 2016, section 256B.072, is amended to read:

186.21 **256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT**  
186.22 **SYSTEM.**

186.23 (a) The commissioner of human services shall establish a performance reporting system  
186.24 for health care providers who provide health care services to public program recipients  
186.25 covered under chapters 256B, 256D, and 256L, reporting separately for managed care and  
186.26 fee-for-service recipients.

186.27 (b) The measures used for the performance reporting system for medical groups ~~shall~~  
186.28 may include measures of care for asthma, diabetes, hypertension, and coronary artery disease  
186.29 and measures of preventive care services. The measures used for the performance reporting  
186.30 system for inpatient hospitals shall include measures of care for acute myocardial infarction,  
186.31 heart failure, and pneumonia, and measures of care and prevention of surgical infections.  
186.32 ~~In the case of a medical group, the measures used shall be consistent with measures published~~  
186.33 ~~by nonprofit Minnesota or national organizations that produce and disseminate health care~~  
186.34 ~~quality measures or evidence-based health care guidelines section 62U.02, subdivision 1,~~  
187.1 paragraph (a), clause (1). In the case of inpatient hospital measures, the commissioner shall  
187.2 appoint the Minnesota Hospital Association and Stratis Health to advise on the development  
187.3 of the performance measures to be used for hospital reporting. To enable a consistent  
187.4 measurement process across the community, the commissioner may use measures of care  
187.5 provided for patients in addition to those identified in paragraph (a). The commissioner  
187.6 shall ensure collaboration with other health care reporting organizations so that the measures  
187.7 described in this section are consistent with those reported by those organizations and used  
187.8 by other purchasers in Minnesota.

187.9 (c) The commissioner may require providers to submit information in a required format  
187.10 to a health care reporting organization or to cooperate with the information collection  
187.11 procedures of that organization. The commissioner may collaborate with a reporting  
187.12 organization to collect information reported and to prevent duplication of reporting.

187.13 (d) By October 1, 2007, and annually thereafter, the commissioner shall report through  
187.14 a public Web site the results by medical groups and hospitals, where possible, of the measures  
187.15 under this section, and shall compare the results by medical groups and hospitals for patients  
187.16 enrolled in public programs to patients enrolled in private health plans. To achieve this  
187.17 reporting, the commissioner may collaborate with a health care reporting organization that  
187.18 operates a Web site suitable for this purpose.

## THE FOLLOWING SECTION IS FROM HOUSE ARTICLE 7.

285.16 Sec. 4. Minnesota Statutes 2016, section 256B.072, is amended to read:

285.17 **256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT**  
285.18 **SYSTEM.**

285.19 Subdivision 1. Performance measures. (a) The commissioner of human services shall  
285.20 establish a performance reporting system for health care providers who provide health care  
285.21 services to public program recipients covered under chapters 256B, 256D, and 256L,  
285.22 reporting separately for managed care and fee-for-service recipients.

285.23 (b) The measures used for the performance reporting system for medical groups ~~shall~~  
285.24 include measures of care for asthma, diabetes, hypertension, and coronary artery disease  
285.25 and measures of preventive care services. The measures used for the performance reporting  
285.26 system for inpatient hospitals shall include measures of care for acute myocardial infarction,  
285.27 heart failure, and pneumonia, and measures of care and prevention of surgical infections.  
285.28 ~~In the case of a medical group, the measures used shall be consistent with measures published~~  
285.29 ~~by nonprofit Minnesota or national organizations that produce and disseminate health care~~  
285.30 ~~quality measures or evidence-based health care guidelines.~~ In the case of inpatient hospital  
285.31 measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis  
285.32 Health to advise on the development of the performance measures to be used for hospital  
286.1 reporting. To enable a consistent measurement process across the community, the  
286.2 commissioner may use measures of care provided for patients in addition to those identified  
286.3 in paragraph (a). The commissioner shall ensure collaboration with other health care reporting  
286.4 organizations so that the measures described in this section are consistent with those reported  
286.5 by those organizations and used by other purchasers in Minnesota.

286.6 (c) The commissioner may require providers to submit information in a required format  
286.7 to a health care reporting organization or to cooperate with the information collection  
286.8 procedures of that organization. The commissioner may collaborate with a reporting  
286.9 organization to collect information reported and to prevent duplication of reporting.

286.10 (d) By October 1, 2007, and annually thereafter, the commissioner shall report through  
286.11 a public Web site the results by medical groups and hospitals, where possible, of the measures  
286.12 under this section, and shall compare the results by medical groups and hospitals for patients  
286.13 enrolled in public programs to patients enrolled in private health plans. To achieve this  
286.14 reporting, the commissioner may collaborate with a health care reporting organization that  
286.15 operates a Web site suitable for this purpose.

187.19 (e) Performance measures must be stratified as provided under section 62U.02,  
 187.20 subdivision 1, paragraph ~~(b)~~ (c), and risk-adjusted as specified in section 62U.02, subdivision  
 187.21 3, paragraph (b).

187.22 (f) Notwithstanding paragraph (b), by January 1, 2019, the commissioner shall consider  
 187.23 and appropriately adjust quality metrics and benchmarks for providers who primarily serve  
 187.24 socioeconomically complex patient populations and request to be scored on additional  
 187.25 measures in this subdivision. This applies to all Minnesota health care programs, including  
 187.26 for patient populations enrolled in health plans, county-based purchasing plans, or managed  
 187.27 care organizations and for value-based purchasing arrangements, including, but not limited  
 187.28 to, initiatives operating under sections 256B.0751, 256B.0753, 256B.0755, 256B.0756, and  
 187.29 256B.0757.

187.30 Sec. 25. Minnesota Statutes 2016, section 256B.0755, subdivision 1, is amended to read:

187.31 Subdivision 1. **Implementation.** (a) The commissioner shall ~~develop and authorize~~  
 187.32 continue and expand a demonstration project established under this section to test alternative  
 187.33 and innovative integrated health care delivery systems partnerships, including accountable  
 187.34 care organizations that provide services to a specified patient population for an agreed-upon  
 188.1 total cost of care or risk/gain sharing payment arrangement. The commissioner shall develop  
 188.2 a request for proposals for participation in the demonstration project in consultation with  
 188.3 hospitals, primary care providers, health plans, and other key stakeholders.

286.16 (e) Performance measures must be stratified as provided under section 62U.02,  
 286.17 subdivision 1, paragraph (b), and risk-adjusted as specified in section 62U.02, subdivision  
 286.18 3, paragraph (b).

286.19 (f) Assessment of patient satisfaction with pain management for the purpose of  
 286.20 determining compensation or quality incentive payments is prohibited. The commissioner  
 286.21 shall require managed care plans, county-based purchasing plans, and integrated health  
 286.22 partnerships to comply with this requirement as a condition of contract. This prohibition  
 286.23 does not apply to:

286.24 (1) assessing patient satisfaction with pain management for the purpose of quality  
 286.25 improvement; and

286.26 (2) pain management as a part of a palliative care treatment plan to treat patients with  
 286.27 cancer or patients receiving hospice care.

286.28 Subd. 2. Adjustment of quality metrics for special populations. Notwithstanding  
 286.29 subdivision 1, paragraph (b), by January 1, 2019, the commissioner shall consider and  
 286.30 appropriately adjust quality metrics and benchmarks for providers who primarily serve  
 286.31 socio-economically complex patient populations and request to be scored on additional  
 286.32 measures in this subdivision. This requirement applies to all medical assistance and  
 286.33 MinnesotaCare programs and enrollees, including persons enrolled in managed care and  
 286.34 county-based purchasing plans or other managed care organizations, persons receiving care  
 287.1 under fee-for-service, and persons receiving care under value-based purchasing arrangements,  
 287.2 including but not limited to initiatives operating under sections 256B.0751, 256B.0753,  
 287.3 256B.0755, 256B.0756, and 256B.0757.

#### THE FOLLOWING SECTIONS ARE FROM HOUSE ARTICLE 1.

38.25 Sec. 26. Minnesota Statutes 2016, section 256B.0755, is amended to read:

38.26 **256B.0755 HEALTH CARE DELIVERY SYSTEMS INTEGRATED HEALTH**  
 38.27 **PARTNERSHIP DEMONSTRATION PROJECT.**

38.28 Subdivision 1. **Implementation.** (a) The commissioner shall ~~develop and authorize~~ a  
 38.29 demonstration project to test alternative and innovative ~~health care delivery systems~~  
 38.30 integrated health partnerships, including accountable care organizations that provide services  
 38.31 to a specified patient population for an agreed-upon total cost of care or risk/gain sharing  
 38.32 payment arrangement. The commissioner shall develop a request for proposals for  
 38.33 participation in the demonstration project in consultation with hospitals, primary care  
 38.34 providers, health plans, and other key stakeholders.

- 188.4 (b) In developing the request for proposals, the commissioner shall:
- 188.5 (1) establish uniform statewide methods of forecasting utilization and cost of care for  
188.6 the appropriate Minnesota public program populations, to be used by the commissioner for  
188.7 ~~the health care delivery system~~ integrated health partnership projects;
- 188.8 (2) identify key indicators of quality, access, patient satisfaction, and other performance  
188.9 indicators that will be measured, in addition to indicators for measuring cost savings;
- 188.10 (3) allow maximum flexibility to encourage innovation and variation so that a variety  
188.11 of provider collaborations are able to become ~~health care delivery systems~~ integrated health  
188.12 partnerships, and may be customized for the special needs and barriers of patient populations  
188.13 experiencing health disparities due to social, economic, racial, or ethnic factors;
- 188.14 (4) encourage and authorize different levels and types of financial risk;
- 188.15 (5) encourage and authorize projects representing a wide variety of geographic locations,  
188.16 patient populations, provider relationships, and care coordination models;
- 188.17 (6) encourage projects that involve close partnerships between the ~~health care delivery~~  
188.18 ~~system~~ integrated health partnership and counties and nonprofit agencies that provide services  
188.19 to patients enrolled with the ~~health care delivery system~~ integrated health partnership,  
188.20 including social services, public health, mental health, community-based services, and  
188.21 continuing care;
- 188.22 (7) encourage projects established by community hospitals, clinics, and other providers  
188.23 in rural communities;
- 188.24 (8) identify required covered services for a total cost of care model or services considered  
188.25 in whole or partially in an analysis of utilization for a risk/gain sharing model;
- 188.26 (9) establish a mechanism to monitor enrollment;
- 188.27 (10) establish quality standards for the ~~delivery system~~ integrated health partnership  
188.28 demonstrations that are appropriate for the particular patient population to be served; and
- 188.29 (11) encourage participation of privately insured population so as to create sufficient  
188.30 alignment in demonstration systems.
- 188.31 (c) To be eligible to participate in ~~the demonstration project~~ an integrated health  
188.32 partnership, a health care delivery system must:

- 39.1 (b) In developing the request for proposals, the commissioner shall:
- 39.2 (1) establish uniform statewide methods of forecasting utilization and cost of care for  
39.3 the appropriate Minnesota public program populations, to be used by the commissioner for  
39.4 ~~the health care delivery system~~ integrated health partnership projects;
- 39.5 (2) identify key indicators of quality, access, patient satisfaction, and other performance  
39.6 indicators that will be measured, in addition to indicators for measuring cost savings;
- 39.7 (3) allow maximum flexibility to encourage innovation and variation so that a variety  
39.8 of provider collaborations are able to become ~~health care delivery systems~~ integrated health  
39.9 partnerships and they can be customized for the special needs and barriers of patient  
39.10 populations experiencing health disparities due to social, economic, racial, or ethnic factors;
- 39.11 (4) encourage and authorize different levels and types of financial risk;
- 39.12 (5) encourage and authorize projects representing a wide variety of geographic locations,  
39.13 patient populations, provider relationships, and care coordination models;
- 39.14 (6) encourage projects that involve close partnerships between the ~~health care delivery~~  
39.15 ~~system~~ integrated health partnerships and counties and nonprofit agencies that provide  
39.16 services to patients enrolled with the ~~health care delivery system~~ integrated health  
39.17 partnerships, including social services, public health, mental health, community-based  
39.18 services, and continuing care;
- 39.19 (7) encourage projects established by community hospitals, clinics, and other providers  
39.20 in rural communities;
- 39.21 (8) identify required covered services for a total cost of care model or services considered  
39.22 in whole or partially in an analysis of utilization for a risk/gain sharing model;
- 39.23 (9) establish a mechanism to monitor enrollment;
- 39.24 (10) establish quality standards for the ~~delivery system~~ integrated health partnership  
39.25 demonstrations that are appropriate for the particular patient population to be served; and
- 39.26 (11) encourage participation of privately insured population so as to create sufficient  
39.27 alignment in ~~demonstration systems~~ integrated health partnerships.
- 39.28 (c) To be eligible to participate in ~~the demonstration project~~, ~~a health care delivery system~~  
39.29 an integrated health partnership must:

189.1 (1) provide required covered services and care coordination to recipients enrolled in the  
 189.2 ~~health care delivery system~~ integrated health partnership;

189.3 (2) establish a process to monitor enrollment and ensure the quality of care provided;

189.4 (3) in cooperation with counties and community social service agencies, coordinate the  
 189.5 delivery of health care services with existing social services programs;

189.6 (4) provide a system for advocacy and consumer protection; and

189.7 (5) adopt innovative and cost-effective methods of care delivery and coordination, which  
 189.8 may include the use of allied health professionals, telemedicine, patient educators, care  
 189.9 coordinators, and community health workers.

189.10 (d) ~~A health care delivery system~~ An integrated health partnership demonstration may  
 189.11 be formed by the following groups of providers of services and suppliers if they have  
 189.12 established a mechanism for shared governance:

189.13 (1) professionals in group practice arrangements;

189.14 (2) networks of individual practices of professionals;

189.15 (3) partnerships or joint venture arrangements between hospitals and health care  
 189.16 professionals;

189.17 (4) hospitals employing professionals; and

189.18 (5) other groups of providers of services and suppliers as the commissioner determines  
 189.19 appropriate.

189.20 A managed care plan or county-based purchasing plan may participate in this  
 189.21 demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

189.22 ~~A health care delivery system~~ An integrated health partnership may contract with a  
 189.23 managed care plan or a county-based purchasing plan to provide administrative services,  
 189.24 including the administration of a payment system using the payment methods established  
 189.25 by the commissioner for ~~health care delivery systems~~ integrated health partnerships.

189.26 (e) The commissioner may require ~~a health care delivery system~~ an integrated health  
 189.27 partnership to enter into additional third-party contractual relationships for the assessment

39.30 (1) provide required covered services and care coordination to recipients enrolled in the  
 39.31 ~~health care delivery system~~ integrated health partnership;

40.1 (2) establish a process to monitor enrollment and ensure the quality of care provided;

40.2 (3) in cooperation with counties and community social service agencies, coordinate the  
 40.3 delivery of health care services with existing social services programs;

40.4 (4) provide a system for advocacy and consumer protection; and

40.5 (5) adopt innovative and cost-effective methods of care delivery and coordination, which  
 40.6 may include the use of allied health professionals, telemedicine, patient educators, care  
 40.7 coordinators, and community health workers.

40.8 (d) ~~A health care delivery system~~ An integrated health partnership demonstration may  
 40.9 be formed by the following groups of providers of services and suppliers if they have  
 40.10 established a mechanism for shared governance:

40.11 (1) professionals in group practice arrangements;

40.12 (2) networks of individual practices of professionals;

40.13 (3) partnerships or joint venture arrangements between hospitals and health care  
 40.14 professionals;

40.15 (4) hospitals employing professionals; and

40.16 (5) other groups of providers of services and suppliers as the commissioner determines  
 40.17 appropriate.

40.18 A managed care plan or county-based purchasing plan may participate in this  
 40.19 demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

40.20 ~~A health care delivery system~~ An integrated health partnership may contract with a  
 40.21 managed care plan or a county-based purchasing plan to provide administrative services,  
 40.22 including the administration of a payment system using the payment methods established  
 40.23 by the commissioner for ~~health care delivery systems~~ integrated health partnerships.

40.24 (e) The commissioner may require ~~a health care delivery system~~ an integrated health  
 40.25 partnership to enter into additional third-party contractual relationships for the assessment

189.28 of risk and purchase of stop loss insurance or another form of insurance risk management  
189.29 related to the delivery of care described in paragraph (c).

189.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

190.1 Sec. 26. Minnesota Statutes 2016, section 256B.0755, subdivision 3, is amended to read:

190.2 Subd. 3. **Accountability.** (a) ~~Health care delivery systems~~ Integrated health partnerships  
190.3 must accept responsibility for the quality of care based on standards established under  
190.4 subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services  
190.5 provided to its enrollees under subdivision 1, paragraph (b), clause (1). Accountability  
190.6 standards must be appropriate to the particular population served.

190.7 (b) ~~A health care delivery system~~ An integrated health partnership may contract and  
190.8 coordinate with providers and clinics for the delivery of services and shall contract with  
190.9 community health clinics, federally qualified health centers, community mental health  
190.10 centers or programs, county agencies, and rural clinics to the extent practicable.

190.11 (c) ~~A health care delivery system~~ An integrated health partnership must indicate how it  
190.12 will coordinate with other services affecting its patients' health, quality of care, and cost of  
190.13 care that are provided by other providers, county agencies, and other organizations in the  
190.14 local service area. The ~~health care delivery system~~ integrated health partnership must indicate  
190.15 how it will engage other providers, counties, and organizations, including county-based  
190.16 purchasing plans, that provide services to patients of the ~~health care delivery system~~  
190.17 integrated health partnership on issues related to local population health, including applicable  
190.18 local needs, priorities, and public health goals. The ~~health care delivery system~~ integrated  
190.19 health partnership must describe how local providers, counties, organizations, including

40.26 of risk and purchase of stop loss insurance or another form of insurance risk management  
40.27 related to the delivery of care described in paragraph (c).

40.28 Subd. 2. **Enrollment.** (a) ~~Individuals eligible for medical assistance or MinnesotaCare~~  
40.29 ~~shall be eligible for enrollment in a health care delivery system~~ an integrated health  
40.30 partnership.

41.1 (b) ~~Eligible applicants and recipients may enroll in a health care delivery system~~ an  
41.2 integrated health partnership ~~if a system~~ an integrated health partnership ~~serves the county~~  
41.3 in which the applicant or recipient resides. If more than one health care delivery system  
41.4 integrated health partnership ~~serves a county, the applicant or recipient shall be allowed to~~  
41.5 choose among the delivery systems integrated health partnerships.

41.6 (c) ~~The commissioner may assign an applicant or recipient to a health care delivery~~  
41.7 system ~~an integrated health partnership~~ if a health care delivery system an integrated health  
41.8 partnership ~~is available and no choice has been made by the applicant or recipient.~~

41.9 Subd. 3. **Accountability.** (a) ~~Health care delivery systems~~ Integrated health partnerships  
41.10 must accept responsibility for the quality of care based on standards established under  
41.11 subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services  
41.12 provided to its enrollees under subdivision 1, paragraph (b), clause (1). Accountability  
41.13 standards must be appropriate to the particular population served.

41.14 (b) ~~A health care delivery system~~ An integrated health partnership may contract and  
41.15 coordinate with providers and clinics for the delivery of services and shall contract with  
41.16 community health clinics, federally qualified health centers, community mental health  
41.17 centers or programs, county agencies, and rural clinics to the extent practicable.

41.18 (c) ~~A health care delivery system~~ An integrated health partnership must indicate how it  
41.19 will coordinate with other services affecting its patients' health, quality of care, and cost of  
41.20 care that are provided by other providers, county agencies, and other organizations in the  
41.21 local service area. The ~~health care delivery system~~ integrated health partnership must indicate  
41.22 how it will engage other providers, counties, and organizations, including county-based  
41.23 purchasing plans, that provide services to patients of the ~~health care delivery system~~  
41.24 integrated health partnership on issues related to local population health, including applicable  
41.25 local needs, priorities, and public health goals. The ~~health care delivery system~~ integrated  
41.26 health partnership must describe how local providers, counties, organizations, including

190.20 county-based purchasing plans, and other relevant purchasers were consulted in developing  
190.21 the application to participate in the demonstration project.

190.22 Sec. 27. Minnesota Statutes 2016, section 256B.0755, subdivision 4, is amended to read:

190.23 Subd. 4. **Payment system.** (a) In developing a payment system for ~~health care delivery~~  
190.24 ~~systems~~ integrated health partnerships, the commissioner shall establish a total cost of care  
190.25 benchmark or a risk/gain sharing payment model to be paid for services provided to the  
190.26 recipients enrolled in ~~a health care delivery system~~ an integrated health partnership.

190.27 (b) The payment system may include incentive payments to ~~health care delivery systems~~  
190.28 integrated health partnerships that meet or exceed annual quality and performance targets  
190.29 realized through the coordination of care.

190.30 (c) An amount equal to the savings realized to the general fund as a result of the  
190.31 demonstration project shall be transferred each fiscal year to the health care access fund.

190.32 (d) The payment system shall include a population-based payment that supports care  
190.33 coordination services for all enrollees served by the integrated health partnerships, and is  
191.1 risk-adjusted to reflect varying levels of care coordination intensiveness for enrollees with  
191.2 chronic conditions, limited English skills, cultural differences, or other barriers to health  
191.3 care. The population-based payment shall be a per member, per month payment paid at least  
191.4 on a quarterly basis. Integrated health partnerships receiving this payment must continue  
191.5 to meet cost and quality metrics under the program to maintain eligibility for the  
191.6 population-based payment. An integrated health partnership is eligible to receive a payment  
191.7 under this paragraph even if the partnership is not participating in a risk-based or gain-sharing  
191.8 payment model and regardless of the size of the patient population served by the integrated  
191.9 health partnership. Any integrated health partnership participant certified as a health care  
191.10 home under section 256B.0751 that agrees to a payment method that includes  
191.11 population-based payments for care coordination is not eligible to receive health care home  
191.12 payment or care coordination fee authorized under section 62U.03 or 256B.0753, subdivision  
191.13 1, or in-reach care coordination under section 256B.0625, subdivision 56, for any medical  
191.14 assistance or MinnesotaCare recipients enrolled or attributed to the integrated health  
191.15 partnership under this demonstration.

191.16 **EFFECTIVE DATE.** This section is effective January 1, 2018.

41.27 county-based purchasing plans, and other relevant purchasers were consulted in developing  
41.28 the application to participate in the demonstration project.

41.29 Subd. 4. **Payment system.** (a) In developing a payment system for ~~health care delivery~~  
41.30 ~~systems~~ integrated health partnerships, the commissioner shall establish a total cost of care  
41.31 benchmark or a risk/gain sharing payment model to be paid for services provided to the  
41.32 recipients enrolled in ~~a health care delivery system~~ an integrated health partnership.

42.1 (b) The payment system may include incentive payments to ~~health care delivery systems~~  
42.2 integrated health partnerships that meet or exceed annual quality and performance targets  
42.3 realized through the coordination of care.

42.4 (c) An amount equal to the savings realized to the general fund as a result of the  
42.5 demonstration project shall be transferred each fiscal year to the health care access fund.

42.6 (d) The payment system shall include a population-based payment that supports care  
42.7 coordination services for all enrollees served by the integrated health partnerships, and is  
42.8 risk-adjusted to reflect varying levels of care coordination intensiveness for enrollees with  
42.9 chronic conditions or limited English skills, or who are homeless or experience health  
42.10 disparities or other barriers to health care. The population-based payment shall be a  
42.11 per-member per-month payment paid at least on a quarterly basis. Integrated health  
42.12 partnerships receiving this payment must continue to meet cost and quality metrics under  
42.13 the program to maintain eligibility for the population-based payment. An integrated health  
42.14 partnership is eligible to receive a payment under this paragraph even if the partnership is  
42.15 not participating in a risk-based or gain-sharing payment model and regardless of the size  
42.16 of the patient population served by the integrated health partnership. Any integrated health  
42.17 partnership participant certified as a health care home under section 256B.0751 that agrees  
42.18 to a payment method that includes population-based payments for care coordination is not  
42.19 eligible to receive health care home payment or care coordination fee authorized under  
42.20 section 62U.23 or 256B.0753, subdivision 1, or in-reach care coordination under section  
42.21 256B.0625, subdivision 56, for any medical assistance or MinnesotaCare recipients enrolled  
42.22 or attributed to the integrated health partnership under this demonstration.

42.23 Subd. 5. **Outpatient prescription drug coverage.** Outpatient prescription drug coverage  
42.24 may be provided through accountable care organizations only if the delivery method qualifies  
42.25 for federal prescription drug rebates.



191.17 Sec. 28. Minnesota Statutes 2016, section 256B.0755, is amended by adding a subdivision  
191.18 to read:

191.19 Subd. 9. **Patient incentives.** The commissioner may authorize an integrated health  
191.20 partnership to provide financial incentives for patients to:

191.21 (1) see a primary care provider for an initial health assessment;

191.22 (2) maintain a continuous relationship with the primary care provider; and

191.23 (3) participate in ongoing health improvement and coordination of care activities.

42.26 Subd. 6. **Federal approval.** The commissioner shall apply for any federal waivers or  
42.27 other federal approval required to implement this section. The commissioner shall also apply  
42.28 for any applicable grant or demonstration under the Patient Protection and Affordable Health  
42.29 Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of  
42.30 2010, Public Law 111-152, that would further the purposes of or assist in the establishment  
42.31 of accountable care organizations.

42.32 Subd. 7. **Expansion.** The commissioner shall expand the demonstration project to include  
42.33 additional medical assistance and MinnesotaCare enrollees, and shall seek participation of  
42.34 Medicare in demonstration projects. The commissioner shall seek to include participation  
43.1 of privately insured persons and Medicare recipients in the health care delivery  
43.2 demonstration. As part of the demonstration expansion, the commissioner may procure the  
43.3 services of the health care delivery systems authorized under this section by geographic  
43.4 area, to supplement or replace the services provided by managed care plans operating under  
43.5 section 256B.69.

43.6 Sec. 27. **[256B.0759] HEALTH CARE DELIVERY SYSTEMS DEMONSTRATION**  
43.7 **PROJECT.**

43.8 Subdivision 1. **Implementation.** (a) The commissioner shall develop and implement a  
43.9 demonstration project to test alternative and innovative health care delivery system payment  
43.10 and care models that provide services to medical assistance and MinnesotaCare enrollees  
43.11 for an agreed-upon, prospective per capita or total cost of care payment. The commissioner  
43.12 shall implement this demonstration project in coordination with, and as an expansion of,  
43.13 the demonstration project authorized under section 256B.0755.

43.14 (b) In developing the demonstration project, the commissioner shall:



- 43.15 (1) establish uniform statewide methods of forecasting utilization and cost of care for  
43.16 the medical assistance and MinnesotaCare populations to be served under the health care  
43.17 delivery system project;
- 43.18 (2) identify key indicators of quality, access, and patient satisfaction, and identify methods  
43.19 to measure cost savings;
- 43.20 (3) allow maximum flexibility to encourage innovation and variation so that a variety  
43.21 of provider collaborations are able to participate as health care delivery systems, and health  
43.22 care delivery systems can be customized to address the special needs and barriers of patient  
43.23 populations;
- 43.24 (4) authorize participation by health care delivery systems representing a variety of  
43.25 geographic locations, patient populations, provider relationships, and care coordination  
43.26 models;
- 43.27 (5) recognize the close partnerships between health care delivery systems and the counties  
43.28 and nonprofit agencies that also provide services to patients enrolled in the health care  
43.29 delivery system, including social services, public health, mental health, community-based  
43.30 services, and continuing care;
- 43.31 (6) identify services to be included under a prospective per capita payment model, and  
43.32 project utilization and cost of these services under a total cost of care risk/gain sharing  
43.33 model;
- 44.1 (7) establish a mechanism to monitor enrollment in each health care delivery system;  
44.2 and
- 44.3 (8) establish quality standards for delivery systems that are appropriate for the specific  
44.4 patient populations served.
- 44.5 Subd. 2. **Requirements for health care delivery systems.** (a) To be eligible to participate  
44.6 in the demonstration project, a health care delivery system must:
- 44.7 (1) provide required services and care coordination to individuals enrolled in the health  
44.8 care delivery system;
- 44.9 (2) establish a process to monitor enrollment and ensure the quality of care provided;
- 44.10 (3) in cooperation with counties and community social service agencies, coordinate the  
44.11 delivery of health care services with existing social services programs;

- 44.12 (4) provide a system for advocacy and consumer protection; and
- 44.13 (5) adopt innovative and cost-effective methods of care delivery and coordination, which  
 44.14 may include the use of allied health professionals, telemedicine and patient educators, care  
 44.15 coordinators, community paramedics, and community health workers.
- 44.16 (b) A health care delivery system may be formed by the following types of health care  
 44.17 providers, if they have established, as applicable, a mechanism for shared governance:
- 44.18 (1) health care providers in group practice arrangements;
- 44.19 (2) networks of health care providers in individual practice;
- 44.20 (3) partnerships or joint venture arrangements between hospitals and health care providers;
- 44.21 (4) hospitals employing or contracting with the necessary range of health care providers;  
 44.22 and
- 44.23 (5) other entities, as the commissioner determines appropriate.
- 44.24 (c) A health care delivery system must contract with a third-party administrator to provide  
 44.25 administrative services, including the administration of the payment system established  
 44.26 under the demonstration project. The third-party administrator must conduct an assessment  
 44.27 of risk, and must purchase stop-loss insurance or another form of insurance risk management  
 44.28 related to the delivery of care. The commissioner may waive the requirement for contracting  
 44.29 with a third-party administrator if the health care delivery system can demonstrate to the  
 44.30 commissioner that it can satisfactorily perform all of the duties assigned to the third-party  
 44.31 administrator.
- 45.1 Subd. 3. **Enrollment.** (a) Individuals eligible for medical assistance or MinnesotaCare  
 45.2 shall be eligible for enrollment in a health care delivery system. Individuals required to  
 45.3 enroll in the prepaid medical assistance program or prepaid MinnesotaCare may opt out of  
 45.4 receiving care from a managed care or county-based purchasing plan, and elect to receive  
 45.5 care through a health care delivery system established under this section.
- 45.6 (b) Eligible applicants and recipients may enroll in a health care delivery system if the  
 45.7 system serves the county in which the applicant or recipient resides. If more than one health  
 45.8 care delivery system serves a county, the applicant or recipient may choose among the  
 45.9 delivery systems. Enrollment in a specific health care delivery system shall be for a 12-month  
 45.10 period, except that enrollees who do not maintain eligibility for medical assistance or  
 45.11 MinnesotaCare shall be disenrolled, and enrollees experiencing a qualifying life event, as  
 45.12 specified by the commissioner, may change health care delivery systems, or opt out of

45.13 receiving coverage through a health care delivery system, within 60 days of the date of the  
 45.14 qualifying life event.

45.15 (c) The commissioner shall assign an applicant or recipient to a health care delivery  
 45.16 system if:

45.17 (1) the applicant or recipient is currently or has recently been attributed to the health  
 45.18 care delivery system as part of an integrated health partnership under section 256B.0755;  
 45.19 or

45.20 (2) no choice has been made by the applicant or recipient. In this case, the commissioner  
 45.21 shall enroll an applicant or recipient based on geographic criteria or based on the health  
 45.22 care providers from whom the applicant or recipient has received prior care.

45.23 Subd. 4. **Accountability.** (a) Health care delivery systems are responsible for the quality  
 45.24 of care based on standards established by the commissioner, and for enrollee cost of care  
 45.25 and utilization of services. The commissioner shall adjust accountability standards including  
 45.26 the quality, cost, and utilization of care to take into account the social, economic, or cultural  
 45.27 barriers experienced by the health care delivery system's patient population.

45.28 (b) A health care delivery system must contract with community health clinics, federally  
 45.29 qualified health centers, community mental health centers or programs, county agencies,  
 45.30 and rural health clinics to the extent practicable.

45.31 (c) A health care delivery system must indicate to the commissioner how it will coordinate  
 45.32 its services with those delivered by other providers, county agencies, and other organizations  
 45.33 in the local service area. The health care delivery system must indicate how it will engage  
 45.34 other providers, counties, and organizations that provide services to patients of the health  
 46.1 care delivery system on issues related to local population health, including applicable local  
 46.2 needs, priorities, and public health goals. The health care delivery system must describe  
 46.3 how local providers, counties, and organizations were consulted in developing the application  
 46.4 submitted to the commissioner requiring participation in the demonstration project.

46.5 Subd. 5. **Payment system.** The commissioner shall develop a payment system for the  
 46.6 health care delivery system project that includes prospective per capita payments, total cost  
 46.7 of care benchmarks, and risk/gain sharing payment options. The payment system may  
 46.8 include incentive payments to health care delivery systems that meet or exceed annual  
 46.9 quality and performance targets through the coordination of care.

46.10 Subd. 6. **Federal waiver or approval.** The commissioner shall seek all federal waivers  
 46.11 or approval necessary to implement the health care delivery system demonstration project.  
 46.12 The commissioner shall notify the chairs and ranking minority members of the legislative

191.24 Sec. 29. Minnesota Statutes 2016, section 256B.0924, is amended by adding a subdivision  
191.25 to read:

191.26 Subd. 4a. Targeted case management through interactive video. (a) Subject to federal  
191.27 approval, contact made for targeted case management by interactive video shall be eligible  
191.28 for payment under subdivision 6 if:

191.29 (1) the person receiving targeted case management services is residing in:

191.30 (i) a hospital;

191.31 (ii) a nursing facility; or

192.1 (iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging  
192.2 establishment or lodging establishment that provides supportive services or health supervision  
192.3 services according to section 157.17 that is staffed 24 hours a day, seven days a week;

192.4 (2) interactive video is in the best interests of the person and is deemed appropriate by  
192.5 the person receiving targeted case management or the person's legal guardian, the case  
192.6 management provider, and the provider operating the setting where the person is residing;

192.7 (3) the use of interactive video is approved as part of the person's written personal service  
192.8 or case plan; and

192.9 (4) interactive video is used for up to, but not more than, 50 percent of the minimum  
192.10 required face-to-face contact.

192.11 (b) The person receiving targeted case management or the person's legal guardian has  
192.12 the right to choose and consent to the use of interactive video under this subdivision and  
192.13 has the right to refuse the use of interactive video at any time.

46.13 committees with jurisdiction over health and human services policy and finance of any  
46.14 federal action related to the request for waivers and approval.

46.15 **EFFECTIVE DATE.** This section is effective January 1, 2018, or upon receipt of  
46.16 federal waivers or approval, whichever is later. The commissioner of human services shall  
46.17 notify the revisor of statutes when federal approval is obtained.

#### THE FOLLOWING SECTION IS FROM HOUSE ARTICLE 6.

278.23 Sec. 16. Minnesota Statutes 2016, section 256B.0924, is amended by adding a subdivision  
278.24 to read:

278.25 Subd. 4a. Targeted case management through interactive video. (a) Subject to federal  
278.26 approval, contact made for targeted case management by interactive video shall be eligible  
278.27 for payment under subdivision 6 if:

278.28 (1) the person receiving targeted case management services is residing in:

278.29 (i) a hospital;

278.30 (ii) a nursing facility; or

279.1 (iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging  
279.2 establishment or lodging establishment that provides supportive services or health supervision  
279.3 services according to section 157.17 that is staffed 24 hours a day, seven days a week;

279.4 (2) interactive video is in the best interests of the person and is deemed appropriate by  
279.5 the person receiving targeted case management or the person's legal guardian, the case  
279.6 management provider, and the provider operating the setting where the person is residing;

279.7 (3) the use of interactive video is approved as part of the person's written personal service  
279.8 or case plan; and

279.9 (4) interactive video is used for up to, but not more than, 50 percent of the minimum  
279.10 required face-to-face contact.

279.11 (b) The person receiving targeted case management or the person's legal guardian has  
279.12 the right to choose and consent to the use of interactive video under this subdivision and  
279.13 has the right to refuse the use of interactive video at any time.

- 192.14 (c) The commissioner shall establish criteria that a targeted case management provider  
 192.15 must attest to in order to demonstrate the safety or efficacy of delivering the service via  
 192.16 interactive video. The attestation may include that the case management provider has:
- 192.17 (1) written policies and procedures specific to interactive video services that are regularly  
 192.18 reviewed and updated;
- 192.19 (2) policies and procedures that adequately address client safety before, during, and after  
 192.20 the interactive video services are rendered;
- 192.21 (3) established protocols addressing how and when to discontinue interactive video  
 192.22 services; and
- 192.23 (4) established a quality assurance process related to interactive video services.
- 192.24 (d) As a condition of payment, the targeted case management provider must document  
 192.25 the following for each occurrence of targeted case management provided by interactive  
 192.26 video:
- 192.27 (1) the time the service began and the time the service ended, including an a.m. and p.m.  
 192.28 designation;
- 192.29 (2) the basis for determining that interactive video is an appropriate and effective means  
 192.30 for delivering the service to the person receiving case management services;
- 192.31 (3) the mode of transmission of the interactive video services and records evidencing  
 192.32 that a particular mode of transmission was utilized;
- 193.1 (4) the location of the originating site and the distant site; and
- 193.2 (5) compliance with the criteria attested to by the targeted case management provider  
 193.3 as provided in paragraph (c).
- 193.4 **EFFECTIVE DATE.** This section is effective three months after federal approval.

- 279.14 (c) The commissioner shall establish criteria that a targeted case management provider  
 279.15 must attest to in order to demonstrate the safety or efficacy of delivering the service via  
 279.16 interactive video. The attestation may include that the case management provider has:
- 279.17 (1) written policies and procedures specific to interactive video services that are regularly  
 279.18 reviewed and updated;
- 279.19 (2) policies and procedures that adequately address client safety before, during, and after  
 279.20 the interactive video services are rendered;
- 279.21 (3) established protocols addressing how and when to discontinue interactive video  
 279.22 services; and
- 279.23 (4) established a quality assurance process related to interactive video services.
- 279.24 (d) As a condition of payment, the targeted case management provider must document  
 279.25 the following for each occurrence of targeted case management provided by interactive  
 279.26 video:
- 279.27 (1) the time the service began and the time the service ended, including an a.m. and p.m.  
 279.28 designation;
- 279.29 (2) the basis for determining that interactive video is an appropriate and effective means  
 279.30 for delivering the service to the person receiving case management services;
- 279.31 (3) the mode of transmission of the interactive video services and records evidencing  
 279.32 that a particular mode of transmission was utilized;
- 280.1 (4) the location of the originating site and the distant site; and
- 280.2 (5) compliance with the criteria attested to by the targeted case management provider  
 280.3 as provided in paragraph (c).

**HOUSE ART. 1, SEC. 28-31 - SEE SENATE ART. 8, SEC. 60-63**

**THE FOLLOWING SECTIONS ARE FROM HOUSE ARTICLE 1.**

51.10 Sec. 32. Minnesota Statutes 2016, section 256B.15, subdivision 1, is amended to read:

51.11 Subdivision 1. **Policy and applicability.** (a) It is the policy of this state that individuals  
51.12 or couples, either or both of whom participate in the medical assistance program, use their  
51.13 own assets to pay their share of the cost of their care during or after their enrollment in the  
51.14 program according to applicable federal law and the laws of this state. The following  
51.15 provisions apply:

51.16 (1) subdivisions 1c to 1k shall not apply to claims arising under this section which are  
51.17 presented under section 525.313;

51.18 (2) the provisions of subdivisions 1c to 1k expanding the interests included in an estate  
51.19 for purposes of recovery under this section give effect to the provisions of United States  
51.20 Code, title 42, section 1396p, governing recoveries, but do not give rise to any express or  
51.21 implied liens in favor of any other parties not named in these provisions;

51.22 (3) the continuation of a recipient's life estate or joint tenancy interest in real property  
51.23 after the recipient's death for the purpose of recovering medical assistance under this section  
51.24 modifies common law principles holding that these interests terminate on the death of the  
51.25 holder;

51.26 (4) all laws, rules, and regulations governing or involved with a recovery of medical  
51.27 assistance shall be liberally construed to accomplish their intended purposes;

51.28 (5) a deceased recipient's life estate and joint tenancy interests continued under this  
51.29 section shall be owned by the remainderpersons or surviving joint tenants as their interests  
51.30 may appear on the date of the recipient's death. They shall not be merged into the remainder  
51.31 interest or the interests of the surviving joint tenants by reason of ownership. They shall be  
51.32 subject to the provisions of this section. Any conveyance, transfer, sale, assignment, or  
51.33 encumbrance by a remainderperson, a surviving joint tenant, or their heirs, successors, and  
52.1 assigns shall be deemed to include all of their interest in the deceased recipient's life estate  
52.2 or joint tenancy interest continued under this section; and

52.3 (6) the provisions of subdivisions 1c to 1k continuing a recipient's joint tenancy interests  
52.4 in real property after the recipient's death do not apply to a homestead owned of record, on  
52.5 the date the recipient dies, by the recipient and the recipient's spouse as joint tenants with  
52.6 a right of survivorship. Homestead means the real property occupied by the surviving joint  
52.7 tenant spouse as their sole residence on the date the recipient dies and classified and taxed  
52.8 to the recipient and surviving joint tenant spouse as homestead property for property tax  
52.9 purposes in the calendar year in which the recipient dies. For purposes of this exemption,  
52.10 real property the recipient and their surviving joint tenant spouse purchase solely with the  
52.11 proceeds from the sale of their prior homestead, own of record as joint tenants, and qualify

52.12 as homestead property under section 273.124 in the calendar year in which the recipient  
52.13 dies and prior to the recipient's death shall be deemed to be real property classified and  
52.14 taxed to the recipient and their surviving joint tenant spouse as homestead property in the  
52.15 calendar year in which the recipient dies. The surviving spouse, or any person with personal  
52.16 knowledge of the facts, may provide an affidavit describing the homestead property affected  
52.17 by this clause and stating facts showing compliance with this clause. The affidavit shall be  
52.18 prima facie evidence of the facts it states.

52.19 (b) For purposes of this section, "medical assistance" includes the medical assistance  
52.20 program under this chapter, the general assistance medical care program formerly codified  
52.21 under chapter 256D, and alternative care for nonmedical assistance recipients under section  
52.22 256B.0913.

52.23 (c) For purposes of this section, ~~beginning January 1, 2010,~~ "medical assistance" does  
52.24 not include Medicare cost-sharing benefits in accordance with United States Code, title 42,  
52.25 section 1396p.

52.26 (d) All provisions in this subdivision, and subdivisions 1d, 1f, 1g, 1h, 1i, and 1j, related  
52.27 to the continuation of a recipient's life estate or joint tenancy interests in real property after  
52.28 the recipient's death for the purpose of recovering medical assistance, are effective only for  
52.29 life estates and joint tenancy interests established on or after August 1, 2003. For purposes  
52.30 of this paragraph, medical assistance does not include alternative care.

52.31 **EFFECTIVE DATE.** This section is effective the day following final enactment and  
52.32 applies retroactively to estate claims pending on or after July 1, 2016, and to the estates of  
52.33 people who died on or after July 1, 2016.

53.1 Sec. 33. Minnesota Statutes 2016, section 256B.15, subdivision 1a, is amended to read:

53.2 Subd. 1a. **Estates subject to claims.** (a) If a person receives medical assistance hereunder,  
53.3 on the person's death, if single, or on the death of the survivor of a married couple, either  
53.4 or both of whom received medical assistance, or as otherwise provided for in this section,  
53.5 the amount paid for medical assistance as limited under subdivision 2 for the person and  
53.6 spouse shall be filed as a claim against the estate of the person or the estate of the surviving  
53.7 spouse in the court having jurisdiction to probate the estate or to issue a decree of descent  
53.8 according to sections 525.31 to 525.313.

53.9 (b) For the purposes of this section, the person's estate must consist of:

53.10 (1) the person's probate estate;

53.11 (2) all of the person's interests or proceeds of those interests in real property the person  
 53.12 owned as a life tenant or as a joint tenant with a right of survivorship at the time of the  
 53.13 person's death;

53.14 (3) all of the person's interests or proceeds of those interests in securities the person  
 53.15 owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time  
 53.16 of the person's death, to the extent the interests or proceeds of those interests become part  
 53.17 of the probate estate under section 524.6-307;

53.18 (4) all of the person's interests in joint accounts, multiple-party accounts, and pay-on-death  
 53.19 accounts, brokerage accounts, investment accounts, or the proceeds of those accounts, as  
 53.20 provided under sections 524.6-201 to 524.6-214 at the time of the person's death to the  
 53.21 extent the interests become part of the probate estate under section 524.6-207; and

53.22 (5) assets conveyed to a survivor, heir, or assign of the person through survivorship,  
 53.23 living trust, or other arrangements.

53.24 (c) For the purpose of this section and recovery in a surviving spouse's estate for medical  
 53.25 assistance paid for a predeceased spouse, the estate must consist of all of the legal title and  
 53.26 interests the deceased individual's predeceased spouse had in jointly owned or marital  
 53.27 property at the time of the spouse's death, as defined in subdivision 2b, and the proceeds of  
 53.28 those interests, that passed to the deceased individual or another individual, a survivor, an  
 53.29 heir, or an assign of the predeceased spouse through a joint tenancy, tenancy in common,  
 53.30 survivorship, life estate, living trust, or other arrangement. A deceased recipient who, at  
 53.31 death, owned the property jointly with the surviving spouse shall have an interest in the  
 53.32 entire property.

54.1 (d) For the purpose of recovery in a single person's estate or the estate of a survivor of  
 54.2 a married couple, "other arrangement" includes any other means by which title to all or any  
 54.3 part of the jointly owned or marital property or interest passed from the predeceased spouse  
 54.4 to another including, but not limited to, transfers between spouses which are permitted,  
 54.5 prohibited, or penalized for purposes of medical assistance.

54.6 (e) A claim shall be filed if medical assistance was rendered for either or both persons  
 54.7 under one of the following circumstances:

54.8 ~~(1) the person was over 55 years of age, and received services under this chapter prior~~  
 54.9 ~~to January 1, 2014;~~

54.10 ~~(2)~~ (1) the person resided in a medical institution for six months or longer, received  
 54.11 services under this chapter, and, at the time of institutionalization or application for medical  
 54.12 assistance, whichever is later, the person could not have reasonably been expected to be



- 54.13 discharged and returned home, as certified in writing by the person's treating physician. For  
 54.14 purposes of this section only, a "medical institution" means a skilled nursing facility,  
 54.15 intermediate care facility, intermediate care facility for persons with developmental  
 54.16 disabilities, nursing facility, or inpatient hospital;
- 54.17 ~~(2)~~ (2) the person received general assistance medical care services under the program  
 54.18 formerly codified under chapter 256D; or
- 54.19 ~~(4)~~ (3) the person was 55 years of age or older and received medical assistance services  
 54.20 on or after January 1, 2014, that consisted of nursing facility services, home and  
 54.21 community-based services, or related hospital and prescription drug benefits.
- 54.22 (f) The claim shall be considered an expense of the last illness of the decedent for the  
 54.23 purpose of section 524.3-805. Notwithstanding any law or rule to the contrary, a state or  
 54.24 county agency with a claim under this section must be a creditor under section 524.6-307.  
 54.25 Any statute of limitations that purports to limit any county agency or the state agency, or  
 54.26 both, to recover for medical assistance granted hereunder shall not apply to any claim made  
 54.27 hereunder for reimbursement for any medical assistance granted hereunder. Notice of the  
 54.28 claim shall be given to all heirs and devisees of the decedent, and to other persons with an  
 54.29 ownership interest in the real property owned by the decedent at the time of the decedent's  
 54.30 death, whose identity can be ascertained with reasonable diligence. The notice must include  
 54.31 procedures and instructions for making an application for a hardship waiver under subdivision  
 54.32 5; time frames for submitting an application and determination; and information regarding  
 54.33 appeal rights and procedures. Counties are entitled to one-half of the nonfederal share of  
 54.34 medical assistance collections from estates that are directly attributable to county effort.  
 55.1 Counties are entitled to ten percent of the collections for alternative care directly attributable  
 55.2 to county effort.
- 55.3 **EFFECTIVE DATE.** This section is effective the day following final enactment and  
 55.4 applies retroactively to estate claims pending on or after July 1, 2016, and to the estates of  
 55.5 people who died on or after July 1, 2016.
- 55.6 Sec. 34. Minnesota Statutes 2016, section 256B.15, subdivision 2, is amended to read:
- 55.7 Subd. 2. **Limitations on claims.** (a) For services rendered prior to January 1, 2014, the  
 55.8 claim shall include only the total amount of medical assistance rendered after age 55 or  
 55.9 during a period of institutionalization described in subdivision 1a, paragraph (c), and the  
 55.10 total amount of general assistance medical care rendered under the program formerly codified  
 55.11 under chapter 256D, and shall not include interest.
- 55.12 (b) For services rendered on or after January 1, 2014, (a) The claim shall include only:

55.13 (1) the amount of medical assistance rendered to recipients 55 years of age or older ~~and~~  
 55.14 that consisted of nursing facility services, home and community-based services, and related  
 55.15 hospital and prescription drug services; ~~and~~

55.16 (2) the total amount of medical assistance rendered during a period of institutionalization  
 55.17 described in subdivision 1a, paragraph (e), clause ~~(2)~~; (1); and

55.18 (3) the total amount of general assistance medical care rendered under the program  
 55.19 formerly codified under chapter 256D.

55.20 The claim shall not include interest. For the purposes of this section, "home and  
 55.21 community-based services" has the same meaning it has when used in United States Code,  
 55.22 title 42, section 1396p(b)(1)(B)(i), and includes the alternative care program under section  
 55.23 256B.0913, even for periods when alternative care services receive only state funding.

55.24 ~~(e)~~ (b) Claims that have been allowed but not paid shall bear interest according to section  
 55.25 524.3-806, paragraph (d). A claim against the estate of a surviving spouse who did not  
 55.26 receive medical assistance, for medical assistance rendered for the predeceased spouse,  
 55.27 shall be payable from the full value of all of the predeceased spouse's assets and interests  
 55.28 which are part of the surviving spouse's estate under subdivisions 1a and 2b. Recovery of  
 55.29 medical assistance expenses in the nonrecipient surviving spouse's estate is limited to the  
 55.30 value of the assets of the estate that were marital property or jointly owned property at any  
 55.31 time during the marriage. The claim is not payable from the value of assets or proceeds of  
 55.32 assets in the estate attributable to a predeceased spouse whom the individual married after  
 55.33 the death of the predeceased recipient spouse for whom the claim is filed or from assets and  
 56.1 the proceeds of assets in the estate which the nonrecipient decedent spouse acquired with  
 56.2 assets which were not marital property or jointly owned property after the death of the  
 56.3 predeceased recipient spouse. Claims for alternative care shall be net of all premiums paid  
 56.4 under section 256B.0913, subdivision 12, on or after July 1, 2003, and shall be limited to  
 56.5 services provided on or after July 1, 2003. Claims against marital property shall be limited  
 56.6 to claims against recipients who died on or after July 1, 2009.

56.7 **EFFECTIVE DATE.** This section is effective the day following final enactment and  
 56.8 applies retroactively to estate claims pending on or after July 1, 2016, and to the estates of  
 56.9 people who died on or after July 1, 2016.

193.5 Sec. 30. Minnesota Statutes 2016, section 256B.196, subdivision 2, is amended to read:

193.6 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision  
 193.7 3, the commissioner shall determine the fee-for-service outpatient hospital services upper  
 193.8 payment limit for nonstate government hospitals. The commissioner shall then determine  
 193.9 the amount of a supplemental payment to Hennepin County Medical Center and Regions  
 193.10 Hospital for these services that would increase medical assistance spending in this category

56.10 Sec. 35. Minnesota Statutes 2016, section 256B.196, subdivision 2, is amended to read:

56.11 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision  
 56.12 3, the commissioner shall determine the fee-for-service outpatient hospital services upper  
 56.13 payment limit for nonstate government hospitals. The commissioner shall then determine  
 56.14 the amount of a supplemental payment to Hennepin County Medical Center and Regions  
 56.15 Hospital for these services that would increase medical assistance spending in this category

193.11 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.  
 193.12 In making this determination, the commissioner shall allot the available increases between  
 193.13 Hennepin County Medical Center and Regions Hospital based on the ratio of medical  
 193.14 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner  
 193.15 shall adjust this allotment as necessary based on federal approvals, the amount of  
 193.16 intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,  
 193.17 in order to maximize the additional total payments. The commissioner shall inform Hennepin  
 193.18 County and Ramsey County of the periodic intergovernmental transfers necessary to match  
 193.19 federal Medicaid payments available under this subdivision in order to make supplementary  
 193.20 medical assistance payments to Hennepin County Medical Center and Regions Hospital  
 193.21 equal to an amount that when combined with existing medical assistance payments to  
 193.22 nonstate governmental hospitals would increase total payments to hospitals in this category  
 193.23 for outpatient services to the aggregate upper payment limit for all hospitals in this category  
 193.24 in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make  
 193.25 supplementary payments to Hennepin County Medical Center and Regions Hospital.

193.26 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall  
 193.27 determine an upper payment limit for physicians and other billing professionals affiliated  
 193.28 with Hennepin County Medical Center and with Regions Hospital. The upper payment limit  
 193.29 shall be based on the average commercial rate or be determined using another method  
 193.30 acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall  
 193.31 inform Hennepin County and Ramsey County of the periodic intergovernmental transfers  
 193.32 necessary to match the federal Medicaid payments available under this subdivision in order  
 193.33 to make supplementary payments to physicians and other billing professionals affiliated  
 193.34 with Hennepin County Medical Center and to make supplementary payments to physicians  
 194.1 and other billing professionals affiliated with Regions Hospital through HealthPartners  
 194.2 Medical Group equal to the difference between the established medical assistance payment  
 194.3 for physician and other billing professional services and the upper payment limit. Upon  
 194.4 receipt of these periodic transfers, the commissioner shall make supplementary payments  
 194.5 to physicians and other billing professionals affiliated with Hennepin County Medical Center  
 194.6 and shall make supplementary payments to physicians and other billing professionals  
 194.7 affiliated with Regions Hospital through HealthPartners Medical Group.

194.8 (c) Beginning January 1, 2010, Hennepin County and Ramsey County may make monthly  
 194.9 voluntary intergovernmental transfers to the commissioner in amounts not to exceed  
 194.10 \$12,000,000 per year from Hennepin County and \$6,000,000 per year from Ramsey County.  
 194.11 The commissioner shall increase the medical assistance capitation payments to any licensed  
 194.12 health plan under contract with the medical assistance program that agrees to make enhanced  
 194.13 payments to Hennepin County Medical Center or Regions Hospital. The increase shall be  
 194.14 in an amount equal to the annual value of the monthly transfers plus federal financial  
 194.15 participation, with each health plan receiving its pro rata share of the increase based on the  
 194.16 pro rata share of medical assistance admissions to Hennepin County Medical Center and  
 194.17 Regions Hospital by those plans. For the purposes of this paragraph, "the base amount"

56.16 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.  
 56.17 In making this determination, the commissioner shall allot the available increases between  
 56.18 Hennepin County Medical Center and Regions Hospital based on the ratio of medical  
 56.19 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner  
 56.20 shall adjust this allotment as necessary based on federal approvals, the amount of  
 56.21 intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,  
 56.22 in order to maximize the additional total payments. The commissioner shall inform Hennepin  
 56.23 County and Ramsey County of the periodic intergovernmental transfers necessary to match  
 56.24 federal Medicaid payments available under this subdivision in order to make supplementary  
 56.25 medical assistance payments to Hennepin County Medical Center and Regions Hospital  
 56.26 equal to an amount that when combined with existing medical assistance payments to  
 56.27 nonstate governmental hospitals would increase total payments to hospitals in this category  
 56.28 for outpatient services to the aggregate upper payment limit for all hospitals in this category  
 56.29 in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make  
 56.30 supplementary payments to Hennepin County Medical Center and Regions Hospital.

56.31 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall  
 56.32 determine an upper payment limit for physicians and other billing professionals affiliated  
 56.33 with Hennepin County Medical Center and with Regions Hospital. The upper payment limit  
 56.34 shall be based on the average commercial rate or be determined using another method  
 57.1 acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall  
 57.2 inform Hennepin County and Ramsey County of the periodic intergovernmental transfers  
 57.3 necessary to match the federal Medicaid payments available under this subdivision in order  
 57.4 to make supplementary payments to physicians and other billing professionals affiliated  
 57.5 with Hennepin County Medical Center and to make supplementary payments to physicians  
 57.6 and other billing professionals affiliated with Regions Hospital through HealthPartners  
 57.7 Medical Group equal to the difference between the established medical assistance payment  
 57.8 for physician and other billing professional services and the upper payment limit. Upon  
 57.9 receipt of these periodic transfers, the commissioner shall make supplementary payments  
 57.10 to physicians and other billing professionals affiliated with Hennepin County Medical Center  
 57.11 and shall make supplementary payments to physicians and other billing professionals  
 57.12 affiliated with Regions Hospital through HealthPartners Medical Group.

57.13 (c) Beginning January 1, 2010, Hennepin County and Ramsey County may make monthly  
 57.14 voluntary intergovernmental transfers to the commissioner in amounts not to exceed  
 57.15 \$12,000,000 per year from Hennepin County and \$6,000,000 per year from Ramsey County.  
 57.16 The commissioner shall increase the medical assistance capitation payments to any licensed  
 57.17 health plan under contract with the medical assistance program that agrees to make enhanced  
 57.18 payments to Hennepin County Medical Center or Regions Hospital. The increase shall be  
 57.19 in an amount equal to the annual value of the monthly transfers plus federal financial  
 57.20 participation, with each health plan receiving its pro rata share of the increase based on the  
 57.21 pro rata share of medical assistance admissions to Hennepin County Medical Center and  
 57.22 Regions Hospital by those plans. Upon the request of the commissioner, health plans shall

194.18 means the total annual value of increased medical assistance capitation payments under this  
 194.19 paragraph in state fiscal year 2018. For managed care contracts beginning on or after July  
 194.20 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance  
 194.21 capitation payments under this paragraph by an amount equal to ten percent of the base  
 194.22 amount, and by an additional ten percent of the base amount for each subsequent contract  
 194.23 year until June 30, 2025. Upon the request of the commissioner, health plans shall submit  
 194.24 individual-level cost data for verification purposes. The commissioner may ratably reduce  
 194.25 these payments on a pro rata basis in order to satisfy federal requirements for actuarial  
 194.26 soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed  
 194.27 health plan that receives increased medical assistance capitation payments under the  
 194.28 intergovernmental transfer described in this paragraph shall increase its medical assistance  
 194.29 payments to Hennepin County Medical Center and Regions Hospital by the same amount  
 194.30 as the increased payments received in the capitation payment described in this paragraph.  
 194.31 This paragraph expires on July 1, 2025.

194.32 (d) For the purposes of this subdivision and subdivision 3, the commissioner shall  
 194.33 determine an upper payment limit for ambulance services affiliated with Hennepin County  
 194.34 Medical Center and the city of St. Paul. The upper payment limit shall be based on the  
 194.35 average commercial rate or be determined using another method acceptable to the Centers  
 195.1 for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and  
 195.2 the city of St. Paul of the periodic intergovernmental transfers necessary to match the federal  
 195.3 Medicaid payments available under this subdivision in order to make supplementary  
 195.4 payments to Hennepin County Medical Center and the city of St. Paul equal to the difference  
 195.5 between the established medical assistance payment for ambulance services and the upper  
 195.6 payment limit. Upon receipt of these periodic transfers, the commissioner shall make  
 195.7 supplementary payments to Hennepin County Medical Center and the city of St. Paul.

57.23 submit individual-level cost data for verification purposes. The commissioner may ratably  
 57.24 reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial  
 57.25 soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed  
 57.26 health plan that receives increased medical assistance capitation payments under the  
 57.27 intergovernmental transfer described in this paragraph shall increase its medical assistance  
 57.28 payments to Hennepin County Medical Center and Regions Hospital by the same amount  
 57.29 as the increased payments received in the capitation payment described in this paragraph.

57.30 (d) For the purposes of this subdivision and subdivision 3, the commissioner shall  
 57.31 determine an upper payment limit for ambulance services affiliated with Hennepin County  
 57.32 Medical Center and the city of St. Paul, and ambulance services owned and operated by  
 57.33 another governmental entity that chooses to participate by requesting the commissioner to  
 57.34 determine an upper payment limit. The upper payment limit shall be based on the average  
 57.35 commercial rate or be determined using another method acceptable to the Centers for  
 58.1 Medicare and Medicaid Services. The commissioner shall inform Hennepin County and  
 58.2 the city of St. Paul, and other participating governmental entities of the periodic  
 58.3 intergovernmental transfers necessary to match the federal Medicaid payments available  
 58.4 under this subdivision in order to make supplementary payments to Hennepin County  
 58.5 Medical Center and the city of St. Paul, and other participating governmental entities equal  
 58.6 to the difference between the established medical assistance payment for ambulance services  
 58.7 and the upper payment limit. Upon receipt of these periodic transfers, the commissioner  
 58.8 shall make supplementary payments to Hennepin County Medical Center and the city of  
 58.9 St. Paul, and other participating governmental entities. A tribal government that owns and  
 58.10 operates an ambulance service is not eligible to participate under this subdivision.

58.11 (e) For the purposes of this subdivision and subdivision 3, the commissioner shall  
 58.12 determine an upper payment limit for physicians, dentists, and other billing professionals  
 58.13 affiliated with the University of Minnesota and University of Minnesota Physicians. The  
 58.14 upper payment limit shall be based on the average commercial rate or be determined using  
 58.15 another method acceptable to the Centers for Medicare and Medicaid Services. The  
 58.16 commissioner shall inform the University of Minnesota Medical School and University of  
 58.17 Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to  
 58.18 match the federal Medicaid payments available under this subdivision in order to make  
 58.19 supplementary payments to physicians, dentists, and other billing professionals affiliated  
 58.20 with the University of Minnesota and the University of Minnesota Physicians equal to the  
 58.21 difference between the established medical assistance payment for physician, dentist, and

195.8 (e) The commissioner shall inform the transferring governmental entities on an ongoing  
 195.9 basis of the need for any changes needed in the intergovernmental transfers in order to  
 195.10 continue the payments under paragraphs (a) to (d), at their maximum level, including  
 195.11 increases in upper payment limits, changes in the federal Medicaid match, and other factors.

195.12 (f) The payments in paragraphs (a) to (d) shall be implemented independently of each  
 195.13 other, subject to federal approval and to the receipt of transfers under subdivision 3.

58.22 other billing professional services and the upper payment limit. Upon receipt of these periodic  
 58.23 transfers, the commissioner shall make supplementary payments to physicians, dentists,  
 58.24 and other billing professionals affiliated with the University of Minnesota and the University  
 58.25 of Minnesota Physicians.

58.26 (f) Beginning January 1, 2018, the University of Minnesota Medical School and the  
 58.27 University of Minnesota School of Dentistry may make monthly voluntary intergovernmental  
 58.28 transfers to the commissioner in amounts not to exceed \$20,000,000 per year from the  
 58.29 University of Minnesota Medical School and \$6,000,000 per year from the University of  
 58.30 Minnesota School of Dentistry. The commissioner shall increase the medical assistance  
 58.31 capitation payments to any licensed health plan under contract with the medical assistance  
 58.32 program that agrees to make enhanced payments to the University of Minnesota and the  
 58.33 University of Minnesota Physicians. The increase shall be in an amount equal to the annual  
 58.34 value of the monthly transfers plus federal financial participation, with each health plan  
 58.35 receiving its pro rata share of the increase based on the pro rata share of medical assistance  
 59.1 services by physicians, dentists, and other billing professionals affiliated with the University  
 59.2 of Minnesota and the University of Minnesota Physicians. Upon the request of the  
 59.3 commissioner, health plans shall submit individual-level cost data for verification purposes.  
 59.4 The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy  
 59.5 federal requirements for actuarial soundness. If payments are reduced, transfers shall be  
 59.6 reduced accordingly. Any licensed health plan that receives increased medical assistance  
 59.7 capitation payments under the intergovernmental transfer described in this paragraph shall  
 59.8 increase its medical assistance payments to the University of Minnesota and the University  
 59.9 of Minnesota Physicians by the same amount as the increased payments received in the  
 59.10 capitation payment described in this paragraph.

59.11 (g) The commissioner shall inform the transferring governmental entities on an ongoing  
 59.12 basis of the need for any changes needed in the intergovernmental transfers in order to  
 59.13 continue the payments under paragraphs (a) to ~~(f)~~ (f), at their maximum level, including  
 59.14 increases in upper payment limits, changes in the federal Medicaid match, and other factors.

59.15 ~~(f)~~ (h) The payments in paragraphs (a) to ~~(f)~~ (f) shall be implemented independently of  
 59.16 each other, subject to federal approval and to the receipt of transfers under subdivision 3.

59.17 (i) All of the data and funding transactions related to the payments in paragraphs (a) to  
 59.18 (f) shall be between the commissioner and the governmental entities.

59.19 EFFECTIVE DATE. Paragraph (d) is effective July 1, 2017, or upon federal approval,  
 59.20 whichever is later. The commissioner of human services shall notify the revisor of statutes  
 59.21 when federal approval is received.

59.22 Sec. 36. Minnesota Statutes 2016, section 256B.196, subdivision 3, is amended to read:

59.23 Subd. 3. **Intergovernmental transfers.** Based on the determination by the commissioner  
 59.24 under subdivision 2, Hennepin County and Ramsey County shall make periodic  
 59.25 intergovernmental transfers to the commissioner for the purposes of subdivision 2, paragraphs  
 59.26 (a) and (b). All of the intergovernmental transfers made by Hennepin County shall be used  
 59.27 to match federal payments to Hennepin County Medical Center under subdivision 2,  
 59.28 paragraph (a), and to physicians and other billing professionals affiliated with Hennepin  
 59.29 County Medical Center under subdivision 2, paragraph (b). All of the intergovernmental  
 59.30 transfers made by Ramsey County shall be used to match federal payments to Regions  
 59.31 Hospital under subdivision 2, paragraph (a), and to physicians and other billing professionals  
 59.32 affiliated with Regions Hospital through HealthPartners Medical Group under subdivision  
 59.33 2, paragraph (b). All of the intergovernmental transfer payments made by the University of  
 59.34 Minnesota Medical School and the University of Minnesota School of Dentistry shall be  
 60.1 used to match federal payments to the University of Minnesota and the University of  
 60.2 Minnesota Physicians under subdivision 2, paragraphs (e) and (f).

60.3 Sec. 37. Minnesota Statutes 2016, section 256B.196, subdivision 4, is amended to read:

60.4 Subd. 4. **Adjustments permitted.** (a) The commissioner may adjust the  
 60.5 intergovernmental transfers under subdivision 3 and the payments under subdivision 2,  
 60.6 based on the commissioner's determination of Medicare upper payment limits,  
 60.7 hospital-specific charge limits, hospital-specific limitations on disproportionate share  
 60.8 payments, medical inflation, actuarial certification, average commercial rates for physician  
 60.9 and other professional services, and cost-effectiveness for purposes of federal waivers. Any  
 60.10 adjustments must be made on a proportional basis. The commissioner may make adjustments  
 60.11 under this subdivision only after consultation with the affected counties, university schools,  
 60.12 and hospitals. All payments under subdivision 2 and all intergovernmental transfers under  
 60.13 subdivision 3 are limited to amounts available after all other base rates, adjustments, and  
 60.14 supplemental payments in chapter 256B are calculated.

60.15 (b) The ratio of medical assistance payments specified in subdivision 2 to the voluntary  
 60.16 intergovernmental transfers specified in subdivision 3 shall not be reduced except as provided  
 60.17 under paragraph (a).

60.18 Sec. 38. Minnesota Statutes 2016, section 256B.69, subdivision 5a, is amended to read:

60.19 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and  
 60.20 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner  
 60.21 may issue separate contracts with requirements specific to services to medical assistance  
 60.22 recipients age 65 and older.

60.23 (b) A prepaid health plan providing covered health services for eligible persons pursuant  
 60.24 to chapters 256B and 256L is responsible for complying with the terms of its contract with  
 60.25 the commissioner. Requirements applicable to managed care programs under chapters 256B



60.26 and 256L established after the effective date of a contract with the commissioner take effect  
60.27 when the contract is next issued or renewed.

60.28 (c) The commissioner shall withhold five percent of managed care plan payments under  
60.29 this section and county-based purchasing plan payments under section 256B.692 for the  
60.30 prepaid medical assistance program pending completion of performance targets. Each  
60.31 performance target must be quantifiable, objective, measurable, and reasonably attainable,  
60.32 except in the case of a performance target based on a federal or state law or rule. Criteria  
60.33 for assessment of each performance target must be outlined in writing prior to the contract  
61.1 effective date. Clinical or utilization performance targets and their related criteria must  
61.2 consider evidence-based research and reasonable interventions when available or applicable  
61.3 to the populations served, and must be developed with input from external clinical experts  
61.4 and stakeholders, including managed care plans, county-based purchasing plans, and  
61.5 providers. The managed care or county-based purchasing plan must demonstrate, to the  
61.6 commissioner's satisfaction, that the data submitted regarding attainment of the performance  
61.7 target is accurate. The commissioner shall periodically change the administrative measures  
61.8 used as performance targets in order to improve plan performance across a broader range  
61.9 of administrative services. The performance targets must include measurement of plan  
61.10 efforts to contain spending on health care services and administrative activities. The  
61.11 commissioner may adopt plan-specific performance targets that take into account factors  
61.12 affecting only one plan, including characteristics of the plan's enrollee population. The  
61.13 withheld funds must be returned no sooner than July of the following year if performance  
61.14 targets in the contract are achieved. The commissioner may exclude special demonstration  
61.15 projects under subdivision 23.

61.16 (d) The commissioner shall require that managed care plans use the assessment and  
61.17 authorization processes, forms, timelines, standards, documentation, and data reporting  
61.18 requirements, protocols, billing processes, and policies consistent with medical assistance  
61.19 fee-for-service or the Department of Human Services contract requirements consistent with  
61.20 medical assistance fee-for-service or the Department of Human Services contract  
61.21 requirements for all personal care assistance services under section 256B.0659.

61.22 (e) Effective for services rendered on or after January 1, 2012, the commissioner shall  
61.23 include as part of the performance targets described in paragraph (c) a reduction in the health  
61.24 plan's emergency department utilization rate for medical assistance and MinnesotaCare  
61.25 enrollees, as determined by the commissioner. For 2012, the reduction shall be based on  
61.26 the health plan's utilization in 2009. To earn the return of the withhold each subsequent  
61.27 year, the managed care plan or county-based purchasing plan must achieve a qualifying  
61.28 reduction of no less than ten percent of the plan's emergency department utilization rate for  
61.29 medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described  
61.30 in subdivisions 23 and 28, compared to the previous measurement year until the final  
61.31 performance target is reached. When measuring performance, the commissioner must  
61.32 consider the difference in health risk in a managed care or county-based purchasing plan's

61.33 membership in the baseline year compared to the measurement year, and work with the  
61.34 managed care or county-based purchasing plan to account for differences that they agree  
61.35 are significant.

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

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

62.13 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall  
62.14 include as part of the performance targets described in paragraph (c) a reduction in the plan's  
62.15 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as  
62.16 determined by the commissioner. To earn the return of the withhold each year, the managed  
62.17 care plan or county-based purchasing plan must achieve a qualifying reduction of no less  
62.18 than five percent of the plan's hospital admission rate for medical assistance and  
62.19 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and  
62.20 28, compared to the previous calendar year until the final performance target is reached.  
62.21 When measuring performance, the commissioner must consider the difference in health risk  
62.22 in a managed care or county-based purchasing plan's membership in the baseline year  
62.23 compared to the measurement year, and work with the managed care or county-based  
62.24 purchasing plan to account for differences that they agree are significant.

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

62.31 The withhold described in this paragraph shall continue until there is a 25 percent  
62.32 reduction in the hospital admission rate compared to the hospital admission rates in calendar  
62.33 year 2011, as determined by the commissioner. The hospital admissions in this performance  
62.34 target do not include the admissions applicable to the subsequent hospital admission  
62.35 performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting



63.1 this performance target and shall accept payment withholds that may be returned to the  
63.2 hospitals if the performance target is achieved.

63.3 (g) Effective for services rendered on or after January 1, 2012, the commissioner shall  
63.4 include as part of the performance targets described in paragraph (c) a reduction in the plan's  
63.5 hospitalization admission rates for subsequent hospitalizations within 30 days of a previous  
63.6 hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare  
63.7 enrollees, as determined by the commissioner. To earn the return of the withhold each year,  
63.8 the managed care plan or county-based purchasing plan must achieve a qualifying reduction  
63.9 of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees,  
63.10 excluding enrollees in programs described in subdivisions 23 and 28, of no less than five  
63.11 percent compared to the previous calendar year until the final performance target is reached.

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

63.18 The withhold described in this paragraph must continue for each consecutive contract  
63.19 period until the plan's subsequent hospitalization rate for medical assistance and  
63.20 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and  
63.21 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year  
63.22 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall  
63.23 accept payment withholds that must be returned to the hospitals if the performance target  
63.24 is achieved.

63.25 (h) Effective for services rendered on or after January 1, 2013, through December 31,  
63.26 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under  
63.27 this section and county-based purchasing plan payments under section 256B.692 for the  
63.28 prepaid medical assistance program. The withheld funds must be returned no sooner than  
63.29 July 1 and no later than July 31 of the following year. The commissioner may exclude  
63.30 special demonstration projects under subdivision 23.

63.31 (i) Effective for services rendered on or after January 1, 2014, the commissioner shall  
63.32 withhold three percent of managed care plan payments under this section and county-based  
63.33 purchasing plan payments under section 256B.692 for the prepaid medical assistance  
63.34 program. The withheld funds must be returned no sooner than July 1 and no later than July  
64.1 31 of the following year. The commissioner may exclude special demonstration projects  
64.2 under subdivision 23.

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

64.6 (k) Contracts between the commissioner and a prepaid health plan are exempt from the  
64.7 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and  
64.8 7.

64.9 (l) The return of the withhold under paragraphs (h) and (i) is not subject to the  
64.10 requirements of paragraph (c).

64.11 (m) Managed care plans and county-based purchasing plans shall maintain current and  
64.12 fully executed agreements for all subcontractors, including bargaining groups, for  
64.13 administrative services that are expensed to the state's public health care programs.  
64.14 Subcontractor agreements determined to be material, as defined by the commissioner after  
64.15 taking into account state contracting and relevant statutory requirements, must be in the  
64.16 form of a written instrument or electronic document containing the elements of offer,  
64.17 acceptance, consideration, payment terms, scope, duration of the contract, and how the  
64.18 subcontractor services relate to state public health care programs. Upon request, the  
64.19 commissioner shall have access to all subcontractor documentation under this paragraph.  
64.20 Nothing in this paragraph shall allow release of information that is nonpublic data pursuant  
64.21 to section 13.02.

64.22 (n) Effective for services provided on or after January 1, 2018, through December 31,  
64.23 2018, the commissioner shall withhold two percent of the capitation payment provided to  
64.24 managed care plans under this section, and county-based purchasing plans under section  
64.25 256B.692, for each medical assistance enrollee. The withheld funds must be returned no  
64.26 sooner than July 1 and no later than July 31 of the following year, for capitation payments  
64.27 for enrollees for whom the plan has submitted to the commissioner a verification of coverage  
64.28 form completed and signed by the enrollee. The verification of coverage form must be  
64.29 developed by the commissioner and made available to managed care and county-based  
64.30 purchasing plans. The form must require the enrollee to provide the enrollee's name, street  
64.31 address, and the name of the managed care or county-based purchasing plan selected by or  
64.32 assigned to the enrollee, and must include a signature block that allows the enrollee to attest  
64.33 that the information provided is accurate. A plan shall request that all enrollees complete  
64.34 the verification of coverage form, and shall submit all completed forms to the commissioner  
65.1 by February 28, 2018. If a completed form for an enrollee is not received by the commissioner  
65.2 by that date:

65.3 (1) the commissioner shall not return to the plan funds withheld for that enrollee;

195.14 Sec. 31. Minnesota Statutes 2016, section 256B.69, subdivision 9e, is amended to read:

195.15 Subd. 9e. **Financial audits.** ~~(a) The legislative auditor shall conduct or contract with~~  
 195.16 ~~vendors to conduct independent third party financial audits of the information required to~~  
 195.17 ~~be provided by audit managed care plans and county-based purchasing plans under~~  
 195.18 ~~subdivision 9e, paragraph (b). The audits by the vendors shall be conducted as vendor~~  
 195.19 ~~resources permit and in accordance with generally accepted government auditing standards~~  
 195.20 ~~issued by the United States Government Accountability Office. The contract with the vendors~~  
 195.21 ~~shall be designed and administered so as to render the independent third party audits eligible~~  
 195.22 ~~for a federal subsidy, if available. The contract shall require the audits to include a~~  
 195.23 ~~determination of compliance with the federal Medicaid rate certification process to determine~~  
 195.24 ~~if a managed care plan or county-based purchasing plan used public money in compliance~~  
 195.25 ~~with federal and state laws, rules, and in accordance with provisions in the plan's contract~~  
 195.26 ~~with the commissioner. The legislative auditor shall conduct the audits in accordance with~~  
 195.27 ~~section 3.972, subdivision 2b.~~

195.28 ~~(b) For purposes of this subdivision, "independent third party" means a vendor that is~~  
 195.29 ~~independent in accordance with government auditing standards issued by the United States~~  
 195.30 ~~Government Accountability Office.~~

65.4 (2) the commissioner shall cease making capitation payments to the plan for that enrollee,  
 65.5 effective with the April 2018 coverage month; and

65.6 (3) the commissioner shall disenroll the enrollee from medical assistance, subject to any  
 65.7 enrollee appeal.

65.8 Sec. 39. Minnesota Statutes 2016, section 256B.69, is amended by adding a subdivision  
 65.9 to read:

65.10 Subd. 36. **Competitive bidding and procurement.** (a) For managed care organization  
 65.11 contracts effective on or after January 1, 2019, the commissioner shall utilize a competitive  
 65.12 price and technical bidding program on a regional basis for nonelderly adults and children  
 65.13 who are not eligible on the basis of a disability and are enrolled in medical assistance and  
 65.14 MinnesotaCare. If the commissioner utilizes a competitive price bidding program, the  
 65.15 commissioner shall establish geographic regions for the purposes of competitive price  
 65.16 bidding. The commissioner shall not implement a competitive price bidding program for  
 65.17 more than 40 percent of the regions during each procurement. The commissioner shall  
 65.18 ensure that there is an adequate choice of managed care organizations based on the potential  
 65.19 enrollment, in a manner that is consistent with the requirements of section 256B.694. The  
 65.20 commissioner shall operate the competitive bidding program by region, but shall award  
 65.21 contracts by county and shall allow managed care organizations with a service area consisting  
 65.22 of only a portion of a region to bid on those counties within their service area only. For

65.23 purposes of this subdivision, "managed care organization" means a demonstration provider  
 65.24 as defined in subdivision 2, paragraph (b).

65.25 (b) The commissioner shall provide the scoring weight of selection criteria to be assigned  
 65.26 in the procurement process and include the scoring weight in the request for proposals.  
 65.27 Substantial weight shall be given to county board resolutions and priority areas identified  
 65.28 by counties.

65.29 (c) If a best and final offer is requested, each responding managed care organization  
 65.30 must be offered the opportunity to submit a best and final offer.

65.31 (d) The commissioner, when evaluating proposals, shall consider network adequacy for  
 65.32 dental and other services.

66.1 (e) Notwithstanding sections 13.591 and 13.599, after the managed care organizations  
 66.2 are notified about the award determination, but before contracts are signed, the commissioner  
 66.3 shall provide each managed care organization with its own scoring sheet and supporting  
 66.4 information. The scoring sheet shall not be made available to other managed care  
 66.5 organizations until final contracts are signed.

66.6 (f) A managed care organization that is aggrieved by the commissioner's decision related  
 66.7 to the selection of managed care organizations to deliver services in a county or counties  
 66.8 may appeal the commissioner's decision using the process outlined in section 256B.69,  
 66.9 subdivision 3a, paragraph (d), except that the recommendation of the three-person mediation  
 66.10 panel shall be binding on the commissioner.

66.11 (g) The commissioner shall contract for an independent evaluation of the competitive  
 66.12 price bidding process. The contractor must solicit recommendations from all parties  
 66.13 participating in the competitive price bidding process for service delivery in calendar year  
 66.14 2019 on how the competitive price bidding process may be improved for service delivery  
 66.15 in calendar year 2020 and annually thereafter. The commissioner shall make evaluation  
 66.16 results available to the public on the department's Web site.

66.17 Sec. 40. Minnesota Statutes 2016, section 256B.75, is amended to read:

66.18 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

66.19 (a) For outpatient hospital facility fee payments for services rendered on or after October  
 66.20 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,  
 66.21 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for  
 66.22 which there is a federal maximum allowable payment. Effective for services rendered on  
 66.23 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and  
 66.24 emergency room facility fees shall be increased by eight percent over the rates in effect on

66.25 December 31, 1999, except for those services for which there is a federal maximum allowable  
66.26 payment. Services for which there is a federal maximum allowable payment shall be paid  
66.27 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total  
66.28 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare  
66.29 upper limit. If it is determined that a provision of this section conflicts with existing or  
66.30 future requirements of the United States government with respect to federal financial  
66.31 participation in medical assistance, the federal requirements prevail. The commissioner  
66.32 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial  
66.33 participation resulting from rates that are in excess of the Medicare upper limitations.

67.1 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory  
67.2 surgery hospital facility fee services for critical access hospitals designated under section  
67.3 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the  
67.4 cost-finding methods and allowable costs of the Medicare program. Effective for services  
67.5 provided on or after July 1, 2015, rates established for critical access hospitals under this  
67.6 paragraph for the applicable payment year shall be the final payment and shall not be settled  
67.7 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal  
67.8 year ending in 2016, the rate for outpatient hospital services shall be computed using  
67.9 information from each hospital's Medicare cost report as filed with Medicare for the year  
67.10 that is two years before the year that the rate is being computed. Rates shall be computed  
67.11 using information from Worksheet C series until the department finalizes the medical  
67.12 assistance cost reporting process for critical access hospitals. After the cost reporting process  
67.13 is finalized, rates shall be computed using information from Title XIX Worksheet D series.  
67.14 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs  
67.15 related to rural health clinics and federally qualified health clinics, divided by ancillary  
67.16 charges plus outpatient charges, excluding charges related to rural health clinics and federally  
67.17 qualified health clinics.

67.18 (c) Effective for services provided on or after July 1, 2003, rates that are based on the  
67.19 Medicare outpatient prospective payment system shall be replaced by a budget neutral  
67.20 prospective payment system that is derived using medical assistance data. The commissioner  
67.21 shall provide a proposal to the 2003 legislature to define and implement this provision.

67.22 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,  
67.23 before third-party liability and spenddown, made to hospitals for outpatient hospital facility  
67.24 services is reduced by .5 percent from the current statutory rate.

67.25 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service  
67.26 services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility  
67.27 services before third-party liability and spenddown, is reduced five percent from the current  
67.28 statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from  
67.29 this paragraph.

67.30 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for  
 67.31 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient  
 67.32 hospital facility services before third-party liability and spenddown, is reduced three percent  
 67.33 from the current statutory rates. Mental health services and facilities defined under section  
 67.34 256.969, subdivision 16, are excluded from this paragraph.

68.1 **EFFECTIVE DATE.** This section is effective July 1, 2017.

195.31 Sec. 32. Minnesota Statutes 2016, section 256B.76, subdivision 1, is amended to read:

195.32 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after  
 195.33 October 1, 1992, the commissioner shall make payments for physician services as follows:

196.1 (1) payment for level one Centers for Medicare and Medicaid Services' common  
 196.2 procedural coding system codes titled "office and other outpatient services," "preventive  
 196.3 medicine new and established patient," "delivery, antepartum, and postpartum care," "critical  
 196.4 care," cesarean delivery and pharmacologic management provided to psychiatric patients,  
 196.5 and level three codes for enhanced services for prenatal high risk, shall be paid at the lower  
 196.6 of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the  
 196.7 rate on any procedure code within these categories is different than the rate that would have  
 196.8 been paid under the methodology in section 256B.74, subdivision 2, then the larger rate  
 196.9 shall be paid;

196.10 (2) payments for all other services shall be paid at the lower of (i) submitted charges,  
 196.11 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

196.12 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th  
 196.13 percentile of 1989, less the percent in aggregate necessary to equal the above increases  
 196.14 except that payment rates for home health agency services shall be the rates in effect on  
 196.15 September 30, 1992.

196.16 (b) Effective for services rendered on or after January 1, 2000, payment rates for physician  
 196.17 and professional services shall be increased by three percent over the rates in effect on  
 196.18 December 31, 1999, except for home health agency and family planning agency services.  
 196.19 The increases in this paragraph shall be implemented January 1, 2000, for managed care.

196.20 (c) Effective for services rendered on or after July 1, 2009, payment rates for physician  
 196.21 and professional services shall be reduced by five percent, except that for the period July  
 196.22 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical  
 196.23 assistance and general assistance medical care programs, over the rates in effect on June  
 196.24 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other  
 196.25 outpatient visits, preventive medicine visits and family planning visits billed by physicians,

196.26 advanced practice nurses, or physician assistants in a family planning agency or in one of  
196.27 the following primary care practices: general practice, general internal medicine, general  
196.28 pediatrics, general geriatrics, and family medicine. This reduction and the reductions in  
196.29 paragraph (d) do not apply to federally qualified health centers, rural health centers, and  
196.30 Indian health services. Effective October 1, 2009, payments made to managed care plans  
196.31 and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall  
196.32 reflect the payment reduction described in this paragraph.

196.33 (d) Effective for services rendered on or after July 1, 2010, payment rates for physician  
196.34 and professional services shall be reduced an additional seven percent over the five percent  
197.1 reduction in rates described in paragraph (c). This additional reduction does not apply to  
197.2 physical therapy services, occupational therapy services, and speech pathology and related  
197.3 services provided on or after July 1, 2010. This additional reduction does not apply to  
197.4 physician services billed by a psychiatrist or an advanced practice nurse with a specialty in  
197.5 mental health. Effective October 1, 2010, payments made to managed care plans and  
197.6 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect  
197.7 the payment reduction described in this paragraph.

197.8 (e) Effective for services rendered on or after September 1, 2011, through June 30, 2013,  
197.9 payment rates for physician and professional services shall be reduced three percent from  
197.10 the rates in effect on August 31, 2011. This reduction does not apply to physical therapy  
197.11 services, occupational therapy services, and speech pathology and related services.

197.12 (f) Effective for services rendered on or after September 1, 2014, payment rates for  
197.13 physician and professional services, including physical therapy, occupational therapy, speech  
197.14 pathology, and mental health services shall be increased by five percent from the rates in  
197.15 effect on August 31, 2014. In calculating this rate increase, the commissioner shall not  
197.16 include in the base rate for August 31, 2014, the rate increase provided under section  
197.17 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,  
197.18 rural health centers, and Indian health services. Payments made to managed care plans and  
197.19 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

197.20 (g) Effective for services rendered on or after July 1, 2015, payment rates for physical  
197.21 therapy, occupational therapy, and speech pathology and related services provided by a  
197.22 hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause  
197.23 (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments  
197.24 made to managed care plans and county-based purchasing plans shall not be adjusted to  
197.25 reflect payments under this paragraph.

197.26 (h) Effective for services provided on or after July 1, 2017, through June 30, 2019,  
197.27 payment rates for physician and professional services, shall be reduced by 2.3 percent, and  
197.28 effective for services provided on or after July 1, 2019, payments shall be reduced by three  
197.29 percent. Payments made to managed care plans and county-based purchasing plans shall



197.30 be adjusted to reflect the rate reductions in this paragraph effective January 1, 2018. The  
197.31 services identified in paragraph (g) are not included in the rate reduction described in this  
197.32 paragraph.

198.1 Sec. 33. Minnesota Statutes 2016, section 256B.76, subdivision 2, is amended to read:

198.2 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October  
198.3 1, 1992, the commissioner shall make payments for dental services as follows:

198.4 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent  
198.5 above the rate in effect on June 30, 1992; and

198.6 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile  
198.7 of 1989, less the percent in aggregate necessary to equal the above increases.

198.8 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments  
198.9 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

198.10 (c) Effective for services rendered on or after January 1, 2000, payment rates for dental  
198.11 services shall be increased by three percent over the rates in effect on December 31, 1999.

198.12 (d) Effective for services provided on or after January 1, 2002, payment for diagnostic  
198.13 examinations and dental x-rays provided to children under age 21 shall be the lower of (1)  
198.14 the submitted charge, or (2) 85 percent of median 1999 charges.

198.15 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000,  
198.16 for managed care.

198.17 (f) Effective for dental services rendered on or after October 1, 2010, by a state-operated  
198.18 dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare  
198.19 principles of reimbursement. This payment shall be effective for services rendered on or  
198.20 after January 1, 2011, to recipients enrolled in managed care plans or county-based  
198.21 purchasing plans.

198.22 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in  
198.23 paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal year, a  
198.24 supplemental state payment equal to the difference between the total payments in paragraph  
198.25 (f) and \$1,850,000 shall be paid from the general fund to state-operated services for the  
198.26 operation of the dental clinics.

198.27 (h) ~~If the cost-based payment system for state-operated dental clinics described in~~  
198.28 ~~paragraph (f) does not receive federal approval, then state-operated dental clinics shall be~~



- 198.29 ~~designated as critical access dental providers under subdivision 4, paragraph (b), and shall~~  
198.30 ~~receive the critical access dental reimbursement rate as described under subdivision 4,~~  
198.31 ~~paragraph (a).~~
- 199.1 ~~(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013,~~  
199.2 ~~payment rates for dental services shall be reduced by three percent. This reduction does not~~  
199.3 ~~apply to state-operated dental clinics in paragraph (f).~~
- 199.4 ~~(j) (h) Effective for services rendered on or after January 1, 2014, payment rates for~~  
199.5 ~~dental services shall be increased by five percent from the rates in effect on December 31,~~  
199.6 ~~2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally~~  
199.7 ~~qualified health centers, rural health centers, and Indian health services. Effective January~~  
199.8 ~~1, 2014, payments made to managed care plans and county-based purchasing plans under~~  
199.9 ~~sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in~~  
199.10 ~~this paragraph.~~
- 199.11 ~~(k) Effective for services rendered on or after July 1, 2015, through December 31, 2016,~~  
199.12 ~~the commissioner shall increase payment rates for services furnished by dental providers~~  
199.13 ~~located outside of the seven-county metropolitan area by the maximum percentage possible~~  
199.14 ~~above the rates in effect on June 30, 2015, while remaining within the limits of funding~~  
199.15 ~~appropriated for this purpose. This increase does not apply to state-operated dental clinics~~  
199.16 ~~in paragraph (f), federally qualified health centers, rural health centers, and Indian health~~  
199.17 ~~services. Effective January 1, 2016, through December 31, 2016, payments to managed care~~  
199.18 ~~plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect~~  
199.19 ~~the payment increase described in this paragraph. The commissioner shall require managed~~  
199.20 ~~care and county-based purchasing plans to pass on the full amount of the increase, in the~~  
199.21 ~~form of higher payment rates to dental providers located outside of the seven-county~~  
199.22 ~~metropolitan area.~~
- 199.23 ~~(l) (i) Effective for services provided on or after January 1, 2017, through June 30, 2017,~~  
199.24 ~~the commissioner shall increase payment rates by 9.65 percent for dental services provided~~  
199.25 ~~outside of the seven-county metropolitan area. This increase does not apply to state-operated~~  
199.26 ~~dental clinics in paragraph (f), federally qualified health centers, rural health centers, or~~  
199.27 ~~Indian health services. Effective January 1, 2017, through June 30, 2017, payments to~~  
199.28 ~~managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692~~  
199.29 ~~shall reflect the payment increase described in this paragraph.~~
- 199.30 ~~(j) Effective for services rendered on or after July 1, 2017, payment rates for dental~~  
199.31 ~~services shall be increased by 25 percent. This increase does not apply to state-operated~~  
199.32 ~~dental clinics in paragraph (f), federally qualified health centers, rural health centers, and~~  
199.33 ~~Indian health services when an encounter rate is paid. Payments made to managed care~~

199.34 plans and county-based purchasing plans shall not be adjusted to reflect the payment increase  
 199.35 described in this paragraph.

200.1 Sec. 34. **[256B.7635] REIMBURSEMENT FOR EVIDENCE-BASED PUBLIC**  
 200.2 **HEALTH NURSE HOME VISITS.**

200.3 Effective for services provided on or after January 1, 2018, prenatal and postpartum  
 200.4 follow-up home visits provided by public health nurses or registered nurses supervised by  
 200.5 a public health nurse using evidence-based models shall be paid a minimum of \$140 per  
 200.6 visit. Evidence-based postpartum follow-up home visits must be administered by home  
 200.7 visiting programs that meet the United States Department of Health and Human Services  
 200.8 criteria for evidence-based models and are identified by the commissioner of health as  
 200.9 eligible to be implemented under the Maternal, Infant, and Early Childhood Home Visiting  
 200.10 program. Home visits must target mothers and their children beginning with prenatal visits  
 200.11 through age three for the child.

200.12 Sec. 35. Minnesota Statutes 2016, section 256B.766, is amended to read:

200.13 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

200.14 (a) Effective for services provided on or after July 1, 2009, total payments for basic care  
 200.15 services, shall be reduced by three percent, except that for the period July 1, 2009, through  
 200.16 June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance  
 200.17 and general assistance medical care programs, prior to third-party liability and spenddown  
 200.18 calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services,  
 200.19 occupational therapy services, and speech-language pathology and related services as basic  
 200.20 care services. The reduction in this paragraph shall apply to physical therapy services,  
 200.21 occupational therapy services, and speech-language pathology and related services provided  
 200.22 on or after July 1, 2010.

200.23 (b) Payments made to managed care plans and county-based purchasing plans shall be  
 200.24 reduced for services provided on or after October 1, 2009, to reflect the reduction effective  
 200.25 July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010,  
 200.26 to reflect the reduction effective July 1, 2010.

200.27 (c) Effective for services provided on or after September 1, 2011, through June 30, 2013,  
 200.28 total payments for outpatient hospital facility fees shall be reduced by five percent from the  
 200.29 rates in effect on August 31, 2011.

200.30 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,  
 200.31 total payments for ambulatory surgery centers facility fees, medical supplies and durable  
 200.32 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,  
 200.33 renal dialysis services, laboratory services, public health nursing services, physical therapy

68.2 Sec. 41. **[256B.7635] REIMBURSEMENT FOR EVIDENCE-BASED PUBLIC**  
 68.3 **HEALTH NURSE HOME VISITS.**

68.4 Effective for services provided on or after January 1, 2018, prenatal and postpartum  
 68.5 follow-up home visits provided by public health nurses or registered nurses supervised by  
 68.6 a public health nurse using evidence-based models shall be paid a minimum of \$140 per  
 68.7 visit. Evidence-based postpartum follow-up home visits must be administered by home  
 68.8 visiting programs that meet the United States Department of Health and Human Services  
 68.9 criteria for evidence-based models and are identified by the commissioner of health as  
 68.10 eligible to be implemented under the Maternal, Infant, and Early Childhood Home Visiting  
 68.11 program. Home visits must target mothers and their children beginning with prenatal visits  
 68.12 through age three for the child.

68.13 Sec. 42. Minnesota Statutes 2016, section 256B.766, is amended to read:

68.14 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

68.15 (a) Effective for services provided on or after July 1, 2009, total payments for basic care  
 68.16 services, shall be reduced by three percent, except that for the period July 1, 2009, through  
 68.17 June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance  
 68.18 and general assistance medical care programs, prior to third-party liability and spenddown  
 68.19 calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services,  
 68.20 occupational therapy services, and speech-language pathology and related services as basic  
 68.21 care services. The reduction in this paragraph shall apply to physical therapy services,  
 68.22 occupational therapy services, and speech-language pathology and related services provided  
 68.23 on or after July 1, 2010.

68.24 (b) Payments made to managed care plans and county-based purchasing plans shall be  
 68.25 reduced for services provided on or after October 1, 2009, to reflect the reduction effective  
 68.26 July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010,  
 68.27 to reflect the reduction effective July 1, 2010.

68.28 (c) Effective for services provided on or after September 1, 2011, through June 30, 2013,  
 68.29 total payments for outpatient hospital facility fees shall be reduced by five percent from the  
 68.30 rates in effect on August 31, 2011.

68.31 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,  
 68.32 total payments for ambulatory surgery centers facility fees, medical supplies and durable  
 69.1 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,  
 69.2 renal dialysis services, laboratory services, public health nursing services, physical therapy

201.1 services, occupational therapy services, speech therapy services, eyeglasses not subject to  
 201.2 a volume purchase contract, hearing aids not subject to a volume purchase contract, and  
 201.3 anesthesia services shall be reduced by three percent from the rates in effect on August 31,  
 201.4 2011.

201.5 (e) Effective for services provided on or after September 1, 2014, payments for  
 201.6 ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory  
 201.7 services, public health nursing services, eyeglasses not subject to a volume purchase contract,  
 201.8 and hearing aids not subject to a volume purchase contract shall be increased by three percent  
 201.9 and payments for outpatient hospital facility fees shall be increased by three percent.  
 201.10 Payments made to managed care plans and county-based purchasing plans shall not be  
 201.11 adjusted to reflect payments under this paragraph.

201.12 (f) Payments for medical supplies and durable medical equipment not subject to a volume  
 201.13 purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through  
 201.14 June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable  
 201.15 medical equipment not subject to a volume purchase contract, and prosthetics and orthotics,  
 201.16 provided on or after July 1, 2015, shall be increased by three percent from the rates as  
 201.17 determined under paragraphs (i) and (j).

201.18 (g) Effective for services provided on or after July 1, 2015, payments for outpatient  
 201.19 hospital facility fees, medical supplies and durable medical equipment not subject to a  
 201.20 volume purchase contract, prosthetics, and orthotics, ~~and laboratory services~~ to a hospital  
 201.21 meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4),  
 201.22 shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made  
 201.23 to managed care plans and county-based purchasing plans shall not be adjusted to reflect  
 201.24 payments under this paragraph.

201.25 (h) This section does not apply to physician and professional services, inpatient hospital  
 201.26 services, family planning services, mental health services, dental services, prescription  
 201.27 drugs, medical transportation, federally qualified health centers, rural health centers, Indian  
 201.28 health services, and Medicare cost-sharing.

201.29 (i) Effective for services provided on or after July 1, 2015, the following categories of  
 201.30 durable medical equipment shall be individually priced items: enteral nutrition and supplies,  
 201.31 customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and  
 201.32 durable medical equipment repair and service. This paragraph does not apply to medical  
 201.33 supplies and durable medical equipment subject to a volume purchase contract, products  
 201.34 subject to the preferred diabetic testing supply program, and items provided to dually eligible  
 202.1 recipients when Medicare is the primary payer for the item. The commissioner shall not  
 202.2 apply any medical assistance rate reductions to durable medical equipment as a result of  
 202.3 Medicare competitive bidding.

69.3 services, occupational therapy services, speech therapy services, eyeglasses not subject to  
 69.4 a volume purchase contract, hearing aids not subject to a volume purchase contract, and  
 69.5 anesthesia services shall be reduced by three percent from the rates in effect on August 31,  
 69.6 2011.

69.7 (e) Effective for services provided on or after September 1, 2014, payments for  
 69.8 ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory  
 69.9 services, public health nursing services, eyeglasses not subject to a volume purchase contract,  
 69.10 and hearing aids not subject to a volume purchase contract shall be increased by three percent  
 69.11 and payments for outpatient hospital facility fees shall be increased by three percent.  
 69.12 Payments made to managed care plans and county-based purchasing plans shall not be  
 69.13 adjusted to reflect payments under this paragraph.

69.14 (f) Payments for medical supplies and durable medical equipment not subject to a volume  
 69.15 purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through  
 69.16 June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable  
 69.17 medical equipment not subject to a volume purchase contract, and prosthetics and orthotics,  
 69.18 provided on or after July 1, 2015, shall be increased by three percent from the rates as  
 69.19 determined under paragraphs (i) and (j).

69.20 (g) Effective for services provided on or after July 1, 2015, payments for outpatient  
 69.21 hospital facility fees, medical supplies and durable medical equipment not subject to a  
 69.22 volume purchase contract, prosthetics and orthotics, ~~and laboratory services~~ to a hospital  
 69.23 meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4),  
 69.24 shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made  
 69.25 to managed care plans and county-based purchasing plans shall not be adjusted to reflect  
 69.26 payments under this paragraph.

69.27 (h) This section does not apply to physician and professional services, inpatient hospital  
 69.28 services, family planning services, mental health services, dental services, prescription  
 69.29 drugs, medical transportation, federally qualified health centers, rural health centers, Indian  
 69.30 health services, and Medicare cost-sharing.

69.31 (i) Effective for services provided on or after July 1, 2015, the following categories of  
 69.32 ~~medical supplies and~~ durable medical equipment shall be individually priced items: enteral  
 69.33 nutrition and supplies, customized and other specialized tracheostomy tubes and supplies,  
 69.34 electric patient lifts, and durable medical equipment repair and service. This paragraph does  
 70.1 not apply to medical supplies and durable medical equipment subject to a volume purchase  
 70.2 contract, products subject to the preferred diabetic testing supply program, and items provided  
 70.3 to dually eligible recipients when Medicare is the primary payer for the item. The  
 70.4 commissioner shall not apply any medical assistance rate reductions to durable medical  
 70.5 equipment as a result of Medicare competitive bidding.

202.4 (j) Effective for services provided on or after July 1, 2015, medical assistance payment  
 202.5 rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased  
 202.6 as follows:

202.7 (1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that  
 202.8 were subject to the Medicare competitive bid that took effect in January of 2009 shall be  
 202.9 increased by 9.5 percent; and

202.10 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on  
 202.11 the medical assistance fee schedule, whether or not subject to the Medicare competitive bid  
 202.12 that took effect in January of 2009, shall be increased by 2.94 percent, with this increase  
 202.13 being applied after calculation of any increased payment rate under clause (1).

202.14 This paragraph does not apply to medical supplies and durable medical equipment subject  
 202.15 to a volume purchase contract, products subject to the preferred diabetic testing supply  
 202.16 program, items provided to dually eligible recipients when Medicare is the primary payer  
 202.17 for the item, and individually priced items identified in paragraph (i). Payments made to  
 202.18 managed care plans and county-based purchasing plans shall not be adjusted to reflect the  
 202.19 rate increases in this paragraph.

202.20 (k) Effective for services provided on or after July 1, 2017, through June 30, 2019,  
 202.21 payments for basic care services, including physical therapy services; occupational therapy  
 202.22 services; speech language pathology and related services; ambulatory surgical center facility  
 202.23 fees; medical supplies and durable medical equipment, not subject to a volume purchase  
 202.24 contract; prosthetics; orthotics; renal dialysis services; laboratory services; public health  
 202.25 nursing services; eyeglasses, not subject to a volume purchase contract; hearing aids, not  
 202.26 subject to a volume purchase contract; and anesthesia services shall be reduced by 2.3  
 202.27 percent and effective for services provided on or after July 1, 2019, payments shall be  
 202.28 reduced by three percent. Payments made to managed care plans and county-based purchasing  
 202.29 plans shall be adjusted to reflect the rate reduction in this paragraph effective January 1,  
 202.30 2018. The services identified in paragraph (g) are not included in the rate reduction described  
 202.31 in this paragraph. The services described under section 256B.0625, subdivision 58, are  
 202.32 included in the rate reduction described in this paragraph.

70.6 (j) Effective for services provided on or after July 1, 2015, medical assistance payment  
 70.7 rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased  
 70.8 as follows:

70.9 (1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that  
 70.10 were subject to the Medicare competitive bid that took effect in January of 2009 shall be  
 70.11 increased by 9.5 percent; and

70.12 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on  
 70.13 the medical assistance fee schedule, whether or not subject to the Medicare competitive bid  
 70.14 that took effect in January of 2009, shall be increased by 2.94 percent, with this increase  
 70.15 being applied after calculation of any increased payment rate under clause (1).

70.16 This paragraph does not apply to medical supplies and durable medical equipment subject  
 70.17 to a volume purchase contract, products subject to the preferred diabetic testing supply  
 70.18 program, items provided to dually eligible recipients when Medicare is the primary payer  
 70.19 for the item, and individually priced items identified in paragraph (i). Payments made to  
 70.20 managed care plans and county-based purchasing plans shall not be adjusted to reflect the  
 70.21 rate increases in this paragraph.

70.22 (k) Effective for nonpressure support ventilators provided on or after January 1, 2016,  
 70.23 the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective  
 70.24 for pressure support ventilators provided on or after January 1, 2016, the rate shall be the  
 70.25 lower of the submitted charge or 47 percent above the Medicare fee schedule rate.

202.33 **EFFECTIVE DATE.** The amendment in paragraph (g) is effective the day following  
 202.34 final enactment.

70.26 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2016.

70.27 Sec. 43. **[256B.90] DEFINITIONS.**

70.28 Subdivision 1. **Generally.** For the purposes of sections 256B.90 to 256B.92, the following  
 70.29 terms have the meanings given.

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

70.31 Subd. 3. **Department.** "Department" means the Department of Human Services.

71.1 Subd. 4. **Hospital.** "Hospital" means a public or private institution licensed as a hospital  
 71.2 under section 144.50 that participates in medical assistance.

71.3 Subd. 5. **Medical assistance.** "Medical assistance" means the state's Medicaid program  
 71.4 under title XIX of the Social Security Act and administered according to this chapter.

71.5 Subd. 6. **Potentially avoidable complication.** "Potentially avoidable complication"  
 71.6 means a harmful event or negative outcome with respect to an individual, including an  
 71.7 infection or surgical complication, that: (1) occurs during the individual's transportation to  
 71.8 a hospital or long-term care facility or after the individual's admission to a hospital or  
 71.9 long-term care facility; and (2) may have resulted from the care caused by insufficient  
 71.10 staffing due to nurses' union strikes in the hospital or long-term care facility by licensed  
 71.11 practical nurses or registered nurses, lack of care, or treatment provided during the hospital  
 71.12 or long-term care facility stay or during the individual's transportation to the hospital or  
 71.13 long-term care facility rather than from a natural progression of an underlying disease.

71.14 Subd. 7. **Potentially avoidable event.** "Potentially avoidable event" means a potentially  
 71.15 avoidable complication, potentially avoidable readmission, or a combination of those events.

71.16 Subd. 8. **Potentially avoidable readmission.** "Potentially avoidable readmission" means  
 71.17 a return hospitalization of an individual within a period specified by the commissioner that  
 71.18 may have resulted from deficiencies in the care or treatment provided to the individual  
 71.19 during a previous hospital stay or from deficiencies in posthospital discharge follow-up.  
 71.20 Potentially avoidable readmission does not include a hospital readmission necessitated by  
 71.21 the occurrence of unrelated events after the discharge. Potentially avoidable readmission  
 71.22 includes the readmission of an individual to a hospital for: (1) the same condition or  
 71.23 procedure for which the individual was previously admitted; (2) an infection or other  
 71.24 complication resulting from care previously provided; or (3) a condition or procedure that  
 71.25 indicates that a surgical intervention performed during a previous admission was unsuccessful  
 71.26 in achieving the anticipated outcome.

71.27 Sec. 44. **[256B.91] MEDICAL ASSISTANCE OUTCOMES-BASED PAYMENT**  
 71.28 **PROGRAM.**

71.29 Subdivision 1. **Generally.** The commissioner must establish and implement a medical  
 71.30 assistance outcomes-based payment program as a hospital outcomes program under section  
 71.31 256B.92 to provide hospitals with information and incentives to reduce potentially avoidable  
 71.32 events.

72.1 Subd. 2. **Potentially avoidable event methodology.** (a) The commissioner shall issue  
 72.2 a request for proposals to select a methodology for identifying potentially avoidable events  
 72.3 and for the costs associated with these events, and for measuring hospital performance with  
 72.4 respect to these events.

72.5 (b) The commissioner shall develop definitions for each potentially avoidable event  
 72.6 according to the selected methodology.

72.7 (c) To the extent possible, the methodology shall be one that has been used by other title  
 72.8 XIX programs under the Social Security Act or by commercial payers in health care outcomes  
 72.9 performance measurement and in outcome-based payment programs. The methodology  
 72.10 shall be open, transparent, and available for review by the public.

72.11 Subd. 3. **Medical assistance system waste.** (a) The commissioner must conduct a  
 72.12 comprehensive analysis of relevant state databases to identify waste in the medical assistance  
 72.13 system.

72.14 (b) The analysis must identify instances of potentially avoidable events in medical  
 72.15 assistance, and the costs associated with these events. The overall estimate of waste must  
 72.16 be broken down into actionable categories including but not limited to regions, hospitals,  
 72.17 MCOs, physicians, licensed practical nurses and registered nurses, other unlicensed health  
 72.18 care personnel, service lines, diagnosis-related groups, medical conditions and procedures,  
 72.19 patient characteristics, provider characteristics, and medical assistance program type.

72.20 (c) Information collected from this analysis must be utilized in hospital outcomes  
 72.21 programs described in this section.

72.22 Sec. 45. **[256B.92] HOSPITAL OUTCOMES PROGRAM.**

72.23 Subdivision 1. **Generally.** The hospital outcomes program shall:

72.24 (1) target reduction of potentially avoidable readmissions and complications;

- 72.25 (2) apply to all state acute care hospitals participating in medical assistance. Program  
 72.26 adjustments may be made for certain types of hospitals; and
- 72.27 (3) be implemented in two phases: performance reporting and outcomes-based financial  
 72.28 incentives.
- 72.29 Subd. 2. **Phase 1; performance reporting.** (a) The commissioner shall develop and  
 72.30 maintain a reporting system to provide each hospital in Minnesota with regular confidential  
 72.31 reports regarding the hospital's performance for potentially avoidable readmissions and  
 72.32 potentially avoidable complications.
- 73.1 (b) The commissioner shall:
- 73.2 (1) conduct ongoing analyses of relevant state claims databases to identify instances of  
 73.3 potentially avoidable readmissions and potentially avoidable complications, and the  
 73.4 expenditures associated with these events;
- 73.5 (2) create or locate state readmission and complications norms;
- 73.6 (3) measure actual-to-expected hospital performance compared to state norms;
- 73.7 (4) compare hospitals with peers using risk adjustment procedures that account for the  
 73.8 severity of illness of each hospital's patients;
- 73.9 (5) distribute reports to hospitals to provide actionable information to create policies,  
 73.10 contracts, or programs designed to improve target outcomes; and
- 73.11 (6) foster collaboration among hospitals to share best practices.
- 73.12 (c) A hospital may share the information contained in the outcome performance reports  
 73.13 with physicians and other health care providers providing services at the hospital to foster  
 73.14 coordination and cooperation in the hospital's outcome improvement and waste reduction  
 73.15 initiatives.
- 73.16 Subd. 3. **Phase 2; outcomes-based financial incentives.** Twelve months after  
 73.17 implementation of performance reporting under subdivision 2, the commissioner must  
 73.18 establish financial incentives for a hospital to reduce potentially avoidable readmissions  
 73.19 and potentially avoidable complications.
- 73.20 Subd. 4. **Rate adjustment methodology.** (a) The commissioner must adjust the  
 73.21 reimbursement that a hospital receives under the All Patients Refined Diagnosis-Related  
 73.22 Group inpatient prospective payment system based on the hospital's performance exceeding.

73.23 or failing to achieve, outcome results based on the rates of potentially avoidable readmissions  
 73.24 and potentially avoidable complications.

73.25 (b) The rate adjustment methodology must:

73.26 (1) apply to each hospital discharge;

73.27 (2) determine a hospital-specific potentially avoidable outcome adjustment factor based  
 73.28 on the hospital's actual versus expected risk-adjusted performance compared to the state  
 73.29 norm;

73.30 (3) be based on a retrospective analysis of performance prospectively applied;

73.31 (4) include both rewards and penalties; and

74.1 (5) be communicated to a hospital in a clear and transparent manner.

74.2 Subd. 5. Amendment of contracts. The commissioner must amend contracts with  
 74.3 participating hospitals as necessary to incorporate the financial incentives established under  
 74.4 this section.

74.5 Subd. 6. Budget neutrality. The hospital outcomes program shall be implemented in a  
 74.6 budget-neutral manner with respect to aggregate Medicaid hospital expenditures.

203.1 Sec. 36. Minnesota Statutes 2016, section 256L.03, subdivision 1, is amended to read:

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

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

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



203.13 (d) For the purposes of covered health services under this section, "child" means an  
 203.14 individual younger than 19 years of age.

203.15 Sec. 37. Minnesota Statutes 2016, section 256L.03, subdivision 1a, is amended to read:

203.16 Subd. 1a. **Children; MinnesotaCare health care reform waiver.** Children are eligible  
 203.17 for coverage of all services that are eligible for reimbursement under the medical assistance  
 203.18 program according to chapter 256B, except special education services and that abortion  
 203.19 services under MinnesotaCare shall be limited as provided under subdivision 1. Children  
 203.20 are exempt from the provisions of subdivision 5, regarding co-payments. Children who are  
 203.21 lawfully residing in the United States but who are not "qualified noncitizens" under title IV  
 203.22 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public  
 203.23 Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all  
 203.24 services provided under the medical assistance program according to chapter 256B.

203.25 Sec. 38. Minnesota Statutes 2016, section 256L.03, subdivision 5, is amended to read:

203.26 Subd. 5. **Cost-sharing.** ~~(a) Except as otherwise provided in this subdivision, the~~  
 203.27 ~~MinnesotaCare benefit plan shall include the following cost-sharing requirements for all~~  
 203.28 ~~enrollees:~~

203.29 ~~(1) \$3 per prescription for adult enrollees;~~

203.30 ~~(2) \$25 for eyeglasses for adult enrollees;~~

204.1 ~~(3) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an~~  
 204.2 ~~episode of service which is required because of a recipient's symptoms, diagnosis, or~~  
 204.3 ~~established illness, and which is delivered in an ambulatory setting by a physician or~~  
 204.4 ~~physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse,~~  
 204.5 ~~audiologist, optician, or optometrist;~~

204.6 ~~(4) \$6 for nonemergency visits to a hospital-based emergency room for services provided~~  
 204.7 ~~through December 31, 2010, and \$3.50 effective January 1, 2011; and~~

204.8 ~~(5) a family deductible equal to \$2.75 per month per family and adjusted annually by~~  
 204.9 ~~the percentage increase in the medical care component of the CPI-U for the period of~~  
 204.10 ~~September to September of the preceding calendar year, rounded to the next higher five~~  
 204.11 ~~cent increment.~~

204.12 ~~(b) Paragraph (a) does (a) Co-payments, coinsurance, and deductibles do not apply to~~  
 204.13 ~~children under the age of 21 and to American Indians as defined in Code of Federal~~  
 204.14 ~~Regulations, title 42, section 447.51 600.5.~~

204.15 ~~(e) Paragraph (a), clause (3), does not apply to mental health services.~~

204.16 ~~(d) MinnesotaCare reimbursements to fee-for-service providers and payments to managed~~  
 204.17 ~~care plans or county-based purchasing plans shall not be increased as a result of the reduction~~  
 204.18 ~~of the co-payments in paragraph (a), clause (4), effective January 1, 2011.~~

204.19 ~~(e) The commissioner, through the contracting process under section 256L.12, may~~  
 204.20 ~~allow managed care plans and county-based purchasing plans to waive the family deductible~~  
 204.21 ~~under paragraph (a), clause (5). The value of the family deductible shall not be included in~~  
 204.22 ~~the capitation payment to managed care plans and county-based purchasing plans. Managed~~  
 204.23 ~~care plans and county-based purchasing plans shall certify annually to the commissioner~~  
 204.24 ~~the dollar value of the family deductible.~~

204.25 ~~(f) (b) The commissioner shall increase adjust co-payments, coinsurance, and deductibles~~  
 204.26 ~~for covered services in a manner sufficient to reduce maintain the actuarial value of the~~  
 204.27 ~~benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to~~  
 204.28 ~~eligible recipients or services exempt from cost-sharing under state law. The cost-sharing~~  
 204.29 ~~changes described in this paragraph shall not be implemented prior to January 1, 2016.~~

204.30 ~~(g) (c) The cost-sharing changes authorized under paragraph (f) (b) must satisfy the~~  
 204.31 ~~requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal~~  
 204.32 ~~Regulations, title 42, sections 600.510 and 600.520.~~

204.33 **EFFECTIVE DATE.** This section is effective January 1, 2018.

205.1 Sec. 39. Minnesota Statutes 2016, section 256L.15, subdivision 2, is amended to read:

205.2 Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner  
 205.3 shall establish a sliding fee scale to determine the percentage of monthly individual or family  
 205.4 income that households at different income levels must pay to obtain coverage through the  
 205.5 MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly  
 205.6 individual or family income.

205.7 (b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according  
 205.8 to the premium scale specified in paragraph (d).

205.9 (c) Paragraph (b) does not apply to:

205.10 (1) children 20 years of age or younger; and

205.11 (2) individuals with household incomes below 35 percent of the federal poverty  
 205.12 guidelines.

74.7 Sec. 46. Minnesota Statutes 2016, section 256L.15, subdivision 2, is amended to read:

74.8 Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner  
 74.9 shall establish a sliding fee scale to determine the percentage of monthly individual or family  
 74.10 income that households at different income levels must pay to obtain coverage through the  
 74.11 MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly  
 74.12 individual or family income.

74.13 (b) Beginning ~~January 1, 2014~~ October 1, 2017, MinnesotaCare enrollees shall pay  
 74.14 premiums according to the premium scale specified in paragraph (d).

74.15 (c) Paragraph (b) does not apply to:

74.16 (1) children 20 years of age or younger; and

74.17 (2) individuals with household incomes below 35 percent of the federal poverty  
 74.18 guidelines.

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

205.15 205.16	Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
205.17	35%	55%	<del>\$4</del>
205.18	55%	80%	<del>\$6</del>
205.19	80%	90%	<del>\$8</del>
205.20	90%	100%	<del>\$10</del>
205.21	100%	110%	<del>\$12</del>
205.22	110%	120%	<del>\$14</del>

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

74.21 74.22	Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
74.23			<del>\$4</del>
74.24	35%	55%	<del>\$5</del>
74.25			<del>\$6</del>
74.26	55%	80%	<del>\$7</del>
74.27			<del>\$8</del>
74.28	80%	90%	<del>\$11</del>
74.29			<del>\$10</del>
74.30	90%	100%	<del>\$12</del>
74.31			<del>\$12</del>
74.32	100%	110%	<del>\$13</del>
74.33			<del>\$14</del>
74.34	110%	120%	<del>\$15</del>

205.23	120%	130%	<del>\$15</del>	74.35	120%	130%	<del>\$15</del>
				74.36			<u>\$16</u>
205.24	130%	140%	<del>\$16</del>	75.1	130%	140%	<del>\$16</del>
				75.2			<u>\$18</u>
205.25	140%	150%	<del>\$25</del>	75.3	140%	150%	<del>\$25</del>
				75.4			<u>\$32</u>
205.26	150%	160%	<del>\$29</del> <u>\$37</u>	75.5	150%	160%	<del>\$29</del>
				75.6			<u>\$40</u>
205.27	160%	170%	<del>\$33</del> <u>\$44</u>	75.7	160%	170%	<del>\$33</del>
				75.8			<u>\$48</u>
205.28	170%	180%	<del>\$38</del> <u>\$52</u>	75.9	170%	180%	<del>\$38</del>
				75.10			<u>\$56</u>
205.29	180%	190%	<del>\$43</del> <u>\$61</u>	75.11	180%	190%	<del>\$43</del>
				75.12			<u>\$65</u>
205.30	190%	<u>200%</u>	<del>\$50</del> <u>\$71</u>	75.13	190%		<del>\$50</del>
				75.14			<u>\$75</u>

205.31 200% \$80

205.32 **EFFECTIVE DATE.** This section is effective August 1, 2015.

75.15 200% \$85

75.16 Sec. 47. Laws 1988, chapter 645, section 3, as amended by Laws 1999, chapter 243, article  
75.17 6, section 9, Laws 2000, chapter 490, article 6, section 15, Laws 2008, chapter 154, article  
75.18 2, section 30, and Laws 2013, chapter 143, article 4, section 33, is amended to read:  
75.19 **Sec. 3. TAX; PAYMENT OF EXPENSES.**

75.20 (a) The tax levied by the hospital district under Minnesota Statutes, section 447.34, must  
75.21 not be levied at a rate that exceeds the amount authorized to be levied under that section.  
75.22 The proceeds of the tax may be used for all purposes of the hospital district, except as  
75.23 provided in paragraph (b).

75.24 (b) 0.015 percent of taxable market value of the tax in paragraph (a) may be used by the  
75.25 Cook ambulance service and the Orr ambulance service for the purpose of:

75.26 (1) ambulance acquisitions for the Cook ambulance service and the Orr ambulance  
75.27 service;

75.28 (2) attached and portable equipment for use in and for the ambulances; and

75.29 (3) parts and replacement parts for maintenance and repair of the ambulances, and  
75.30 administrative, operation, or salary expenses for the Cook ambulance service and the Orr  
75.31 ambulance service.

75.32 ~~The money may not be used for administrative, operation, or salary expenses.~~

75.33 (c) The part of the levy referred to in paragraph (b) must be administered by the Cook  
75.34 Hospital and passed on in equal amounts directly to the Cook area ambulance service board  
75.35 and the city of Orr to be used for the purposes in paragraph (b).

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

206.1 Sec. 40. **CAPITATION PAYMENT DELAY.**

206.2 (a) The commissioner of human services shall delay \$54,654,000 of the medical assistance  
206.3 capitation payment to managed care plans and county-based purchasing plans due in April  
206.4 2019 and all of the payment due in May 2019 and the payment due in April 2019 for special

76.2 Sec. 48. **CAPITATION PAYMENT DELAY.**

76.3 (a) The commissioner of human services shall delay \$135,000,000 of the medical  
76.4 assistance and MinnesotaCare capitation payment to managed care plans and county-based  
76.5 purchasing plans due in May 2019 and the payment due in April 2019 for special needs

206.5 needs basic care until July 1, 2019. The payment shall be made no earlier than July 1, 2019,  
 206.6 and no later than July 31, 2019.

206.7 (b) The commissioner of human services shall delay the medical assistance capitation  
 206.8 payment to managed care plans and county-based purchasing plans due in April 2021 and  
 206.9 May 2021 and the payment due in April 2021 for special needs basic care until July 1, 2021.  
 206.10 The payment shall be made no earlier than July 1, 2021, and no later than July 31, 2021.

206.11 Sec. 41. **COMMISSIONER DUTY TO SEEK FEDERAL APPROVAL.**

206.12 The commissioner of human services shall seek federal approval that is necessary to  
 206.13 implement Minnesota Statutes, sections 256B.0621, subdivision 10; 256B.0924, subdivision  
 206.14 4a; and 256B.0625, subdivision 20b, for interactive video contact.

206.15 Sec. 42. **LEGISLATIVE COMMISSION ON MANAGED CARE.**

206.16 Subdivision 1. Establishment. (a) A legislative commission is created to study and  
 206.17 make recommendations to the legislature on issues relating to the competitive bidding  
 206.18 program and procurement process for the medical assistance and MinnesotaCare contracts  
 206.19 with managed care organizations for nonelderly, nondisabled adults and children enrollees.

206.20 (b) For purposes of this section, "managed care organization" means a demonstration  
 206.21 provider as defined under Minnesota Statutes, section 256B.69, subdivision 2.

206.22 Subd. 2. Membership. (a) The commission consists of:

206.23 (1) four members of the senate, two members appointed by the senate majority leader  
 206.24 and two members appointed by the senate minority leader;

206.25 (2) four members of the house of representatives, two members appointed by the speaker  
 206.26 of the house and two members appointed by the minority leader; and

206.27 (3) the commissioner of human services or the commissioner's designee.

206.28 (b) The appointing authorities must make their appointments by July 1, 2017.

76.6 basic care until July 1, 2019. The payment shall be made no earlier than July 1, 2019, and  
 76.7 no later than July 31, 2019.

76.8 (b) The commissioner of human services shall delay \$135,000,000 of the medical  
 76.9 assistance and MinnesotaCare capitation payment to managed care plans and county-based  
 76.10 purchasing plans due in the second quarter of calendar year 2021 and the April 2021 payment  
 76.11 for special needs basic care until July 1, 2021. The payment shall be made no earlier than  
 76.12 July 1, 2021, and no later than July 31, 2021.

**THE FOLLOWING SECTION IS FROM HOUSE ARTICLE 6.**

283.28 Sec. 20. **COMMISSIONER'S DUTY TO SEEK FEDERAL APPROVAL.**

283.29 The commissioner of human services shall seek federal approval that is necessary to  
 283.30 implement Minnesota Statutes, sections 256B.0621, subdivision 10; and 256B.0625,  
 283.31 subdivision 20, for interactive video contact.

- 206.29 (c) The ranking senator from the majority party appointed to the commission shall  
206.30 convene the first meeting no later than September 1, 2017.
- 207.1 (d) The commission shall elect a chair among its members at the first meeting.
- 207.2 (e) Members serve without compensation or reimbursement for expenses, except that  
207.3 legislative members may receive per diem and be reimbursed for expenses as provided in  
207.4 the rules governing their respective bodies.
- 207.5 Subd. 3. **Staff.** The commissioner of human services shall provide staff and administrative  
207.6 and research services, as needed, to the commission.
- 207.7 Subd. 4. **Duties.** (a) The commission shall study, review, and make recommendations  
207.8 on the competitive bidding process for the managed care contracts that provide services to  
207.9 the nonelderly, nondisabled adults and children enrolled in medical assistance and  
207.10 MinnesotaCare. When reviewing the competitive bidding process, the commission shall  
207.11 consider and make recommendations on the following:
- 207.12 (1) the number of geographic regions to be established for competitive bidding and each  
207.13 procurement cycle and the criteria to be used in determining the minimum number of  
207.14 managed care organizations to serve each region or statistical area;
- 207.15 (2) the specifications of the request for proposals, including whether managed care  
207.16 organizations must address in their proposals priority areas identified by counties;
- 207.17 (3) the criteria to be used to determine whether managed care organizations will be  
207.18 requested to provide a best and final offer;
- 207.19 (4) the evaluation process that the commissioner must consider when evaluating each  
207.20 proposal, including the scoring weight to be given when there is a county board resolution  
207.21 identifying a managed care organization preference, and whether consideration shall be  
207.22 given to network adequacy for such services as dental, mental health, and primary care;
- 207.23 (5) the notification process to inform managed care organizations about the award  
207.24 determinations, but before the contracts are signed;
- 207.25 (6) process for appealing the commissioner's decision on the selection of a managed  
207.26 care plan or county-based purchasing plan in a county or counties; and
- 207.27 (7) whether an independent evaluation of the competitive bidding process is necessary,  
207.28 and if so, what the evaluation should entail.

- 207.29 (b) The commissioner shall consider the frequency of the procurement process in terms  
207.30 of how often the commissioner should conduct the procurement of managed care contracts  
207.31 and whether procurement should be conducted on a statewide basis or at staggered times  
207.32 for a limited number of counties within a specified region.
- 208.1 (c) The commission shall review proposed legislation that incorporates new federal  
208.2 regulations into managed care statutes, including the recodification of the managed care  
208.3 requirements in Minnesota Statutes, sections 256B.69 and 256B.692.
- 208.4 (d) The commission shall study, review, and make recommendations on a process that  
208.5 meets federal regulations for ensuring that provider rate increases passed by the legislature  
208.6 and incorporated into the capitated rates paid to managed care organizations are recognized  
208.7 in the rates paid by the managed care organizations to the providers while still providing  
208.8 managed care organizations the flexibility in negotiating rates paid to their provider networks.
- 208.9 (e) The commission shall consult with interested stakeholders and may solicit public  
208.10 testimony, as deemed necessary.
- 208.11 Subd. 5. **Report.** (a) The commission shall report its recommendations to the chairs and  
208.12 ranking minority members of the legislative committees with jurisdiction over health and  
208.13 human services policy and finance by February 15, 2018. The report shall include any draft  
208.14 legislation necessary to implement the recommendations.
- 208.15 (b) The commission shall provide preliminary recommendations to the commissioner  
208.16 of human services to be used by the commissioner if the commissioner decides to conduct  
208.17 a procurement for managed care contracts for the 2019 contract year.
- 208.18 Subd. 6. **Open meetings.** The commission is subject to Minnesota Statutes, section  
208.19 3.055.
- 208.20 Subd. 7. **Expiration.** This section expires June 30, 2018.
- 208.21 Sec. 43. **HEALTH CARE ACCESS FUND ASSESSMENT.**
- 208.22 (a) The commissioner of human services, in consultation with the commissioner of  
208.23 management and budget, shall assess any federal health care reform legislation passed at  
208.24 the federal level on its effect on the MinnesotaCare program and the need for the health  
208.25 care access fund as its continued source of funding.



208.26 (b) The commissioner shall report to the chairs and ranking minority members of the  
 208.27 legislative committees with jurisdiction over health care policy and finance within 90 days  
 208.28 of the passage of any federal health care reform legislation.

208.29 Sec. 44. **OPIOID USE AND ACUPUNCTURE STUDY.**

208.30 (a) Within existing appropriations, the Human Services Policy Committee, established  
 208.31 under Minnesota Statutes, section 256B.0625, subdivision 3c, in consultation with the opioid  
 209.1 prescribing work group, shall study and compare the use of opiates for the treatment of  
 209.2 chronic pain conditions when acupuncture services are also part of the treatment for chronic  
 209.3 pain.

209.4 (b) The committee shall identify a sample of medical assistance recipients who are  
 209.5 utilizing opiate prescriptions for the treatment of chronic pain, and a sample of recipients  
 209.6 who are utilizing opiate prescriptions as well as receiving or have received acupuncture  
 209.7 services as part of their treatment of chronic pain. The two sample groups must be similar  
 209.8 in pain diagnosis, co-morbidities, and demographic characteristics.

209.9 (c) In comparing the sample groups, the committee shall look at each group's number  
 209.10 of opiate prescriptions filled, the number of refills, utilization of other health care services,  
 209.11 and the number of emergency room visits.

209.12 (d) The committee shall report the aggregate findings of the study to the chairs and  
 209.13 ranking minority members of the senate and house of representatives legislative committees  
 209.14 with jurisdiction over health and human services policy and finance by February 15, 2018.  
 209.15 The report shall not contain or disclose any patient identifying data.

## HOUSE ART. 1, SEC. 49 - SEE SENATE ART. 8, SEC. 64

### THE FOLLOWING SECTIONS ARE FROM HOUSE ARTICLE 1.

77.11 Sec. 50. **ENCOUNTER REPORTING OF 340B ELIGIBLE DRUGS.**

77.12 (a) The commissioner of human services, in consultation with federally qualified health  
 77.13 centers, managed care organizations, and contract pharmacies shall develop a report on the  
 77.14 feasibility of a process to identify and report at point of sale the 340B drugs that are dispensed  
 77.15 to enrollees of managed care organizations who are patients of a federally qualified health  
 77.16 center to exclude these claims from the Medicaid drug rebate program and ensure that  
 77.17 duplicate discounts for drugs do not occur.

77.18 (b) By January 1, 2018, the commissioner shall present the report to the chairs and  
77.19 ranking minority members of the house of representatives and senate committees with  
77.20 jurisdiction over medical assistance.

77.21 Sec. 51. **RATE-SETTING ANALYSIS REPORT.**

77.22 The commissioner of human services shall conduct a comprehensive analysis report of  
77.23 the current rate-setting methodology for outpatient, professional, and physician services  
77.24 that do not have a cost-based, federally mandated, or contracted rate. The report shall include  
77.25 recommendations for changes to the existing fee schedule that utilizes the Resource-Based  
77.26 Relative Value System (RBRVS), and alternate payment methodologies for services that  
77.27 do not have relative values, to simplify the fee for service medical assistance rate structure  
77.28 and to improve consistency and transparency. In developing the report, the commissioner  
77.29 shall consult with outside experts in Medicaid financing. The commissioner shall provide  
77.30 a report on the analysis to the chairs and ranking minority members of the legislative  
77.31 committees with jurisdiction over health and human services finance by November 1, 2019.

78.1 Sec. 52. **STUDY OF PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT**  
78.2 **AND SUPPLIES.**

78.3 The commissioner of human services shall study the impact of basing medical assistance  
78.4 payment for durable medical equipment and medical supplies on Medicare payment rates,  
78.5 as limited by the payment provisions in the 21st Century Cures Act, Public Law 114-255,  
78.6 on access by medical assistance enrollees to these items. The study must include  
78.7 recommendations for ensuring and improving access by medical assistance enrollees to  
78.8 durable medical equipment and medical supplies. The commissioner shall report study  
78.9 results and recommendations to the chairs and ranking minority members of the legislative  
78.10 committees with jurisdiction over health and human services policy and finance by February  
78.11 1, 2018.

78.12 Sec. 53. **FEDERAL APPROVAL.**

78.13 The commissioner of human services shall request any federal waivers and approvals  
78.14 necessary to allow the state to retain federal funds accruing in the state's basic health program  
78.15 trust fund, and expend those funds for purposes other than those specified in Code of Federal  
78.16 Regulations, title 42, part 600.705. The commissioner shall report any federal action regarding  
78.17 this request to the chairs and ranking minority members of the legislative committees with  
78.18 jurisdiction over health and human services policy and finance.

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

209.16 Sec. 45. **REVISOR'S INSTRUCTION.**

209.17 The revisor of statutes, in the next edition of Minnesota Statutes, shall change the term  
209.18 "health care delivery system" and similar terms to "integrated health partnership" and similar  
209.19 terms, wherever it appears in Minnesota Statutes, section 256B.0755.

209.20 Sec. 46. **REPEALER.**

209.21 Minnesota Statutes 2016, sections 256B.0659, subdivision 22; 256B.19, subdivision 1c;  
209.22 and 256B.64, are repealed.

78.20 Sec. 54. **FEDERAL WAIVER OR APPROVAL.**

78.21 The commissioner of human services shall seek any federal waiver or approval necessary  
78.22 to implement Minnesota Statutes, section 256B.0644.