SENATE
STATE OF MINNESOTA
EIGHTY-EIGHTH LEGISLATURE

S.F. No. 1099

(SENATE AUTHORS: HAYDEN and Rosen)

DATE	D-PG	OFFICIAL STATUS
03/06/2013	620	Introduction and first reading Referred to Health, Human Services and Housing
03/14/2013	1030	Author added Benson
03/18/2013	1057a	Comm report: To pass as amended and re-refer to Finance
04/08/2013	1687	Author stricken Benson Author added Rosen

A bill for an act

relating to human services; modifying provisions related to health care and health disparities; requiring reports; appropriating money; amending Minnesota Statutes 2012, sections 62Q.19, subdivision 3; 62U.02, subdivision 1; 145.928, by adding a subdivision; 256B.06, subdivision 4, by adding a subdivision; 256B.0625, by adding a subdivision; 256B.0651, by adding subdivisions; 256B.76, subdivision 4, by adding a subdivision; 256B.763.

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

Section 1. Minnesota Statutes 2012, section 62Q.19, subdivision 3, is amended to read:

Subd. 3. ~~**Health plan company**~~ **Essential community provider affiliation.** A health plan company, MinnesotaCare participating entity, or health carrier offering a qualified health plan through the Minnesota Insurance Marketplace must offer a provider contract to any designated essential community provider located within the area served by the health plan company. A health plan company shall not restrict enrollee access to services designated to be provided by the essential community provider for the population that the essential community provider is certified to serve. A health plan company may also make other providers available for these services. A health plan company may require an essential community provider to meet all data requirements, utilization review, and quality assurance requirements on the same basis as other health plan providers.

Sec. 2. Minnesota Statutes 2012, section 62U.02, subdivision 1, is amended to read:

Subdivision 1. **Development.** (a) The commissioner of health shall develop a standardized set of measures by which to assess the quality of health care services offered by health care providers, including health care providers certified as health care homes under section 256B.0751. Quality measures must be based on medical evidence and be

developed through a process in which providers participate. The measures shall be used for the quality incentive payment system developed in subdivision 2 and must:

(1) include uniform definitions, measures, and forms for submission of data, to the greatest extent possible;

(2) seek to avoid increasing the administrative burden on health care providers;

(3) be initially based on existing quality indicators for physician and hospital services, which are measured and reported publicly by quality measurement organizations, including, but not limited to, Minnesota Community Measurement and specialty societies;

(4) place a priority on measures of health care outcomes, rather than process measures, wherever possible; ~~and~~

(5) incorporate measures for primary care, including preventive services, coronary artery and heart disease, diabetes, asthma, depression, and other measures as determined by the commissioner;

(6) ensure that measures are collected and reported by categories of race, ethnicity, language, and other patient characteristics that are known to be correlated with poorer health, access, and quality of care for particular groups of patients, so that the data is useful in identifying and eliminating health disparities; and

(7) ensure that measures used for public reporting or payment incentives are adjusted for patient characteristics that are known to be correlated with poorer health, access, and quality of care, so that quality reports and payment incentives do not create a disadvantage for providers who serve high concentrations of patients who experience the greatest health disparities.

(b) The measures shall be reviewed at least annually by the commissioner.

Sec. 3. Minnesota Statutes 2012, section 145.928, is amended by adding a subdivision to read:

Subd. 15. **Health disparities.** The commissioner of health, in consultation with the commissioner of human services, shall complete an assessment of the methods used by state agencies and the legislature to obtain advice and input from the public on health care programs, policies, and legislation to determine the extent to which the methods used are effective in obtaining advice and input from those patients and populations that experience the greatest health disparities, compared to other patients and populations. The commissioner shall submit a report to the legislature by December 15, 2013, that includes the assessment and comparison of existing public input activities and identifies a range of options for ways of improving public input and advice from patients and populations experiencing the greatest health disparities.

Sec. 4. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(1) refugees admitted to the United States according to United States Code, title 8, section 1157;

(2) persons granted asylum according to United States Code, title 8, section 1158;

(3) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(4) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(5) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning July 1, 2010, children and pregnant women who are noncitizens described in paragraph (b) or who are lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation as provided by the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

(e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(f) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition.

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

(h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment of an emergency medical condition are limited to the following:

(i) services delivered in an emergency room or by an ambulance service licensed under chapter 144E that are directly related to the treatment of an emergency medical condition;

(ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; and

(iii) follow-up services ~~that are directly related to the original service provided to treat the emergency medical condition and are covered by the global payment made to the~~

~~provider~~ provided after discharge from an emergency room or inpatient hospital setting that are necessary to prevent recurrence of a medical emergency.

(2) Services for the treatment of emergency medical conditions do not include:

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ transplants, stem cell transplants, and related care;

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services, except follow-up services in these categories that are covered if they are provided after discharge from an emergency room or inpatient hospital setting and are necessary to prevent recurrence of a medical emergency;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

(viii) dialysis, except as medically necessary after discharge from an emergency room or inpatient hospital setting to prevent recurrence of a medical emergency;

(ix) chemotherapy or therapeutic radiation services, except as medically necessary after discharge from an emergency room or inpatient hospital setting to prevent recurrence of a medical emergency;

(x) rehabilitation services;

(xi) physical, occupational, or speech therapy;

(xii) transportation services;

(xiii) case management;

(xiv) prosthetics, orthotics, durable medical equipment, or medical supplies;

(xv) dental services, except as medically necessary after discharge from an emergency room or inpatient hospital setting to prevent recurrence of a medical emergency;

(xvi) hospice care;

(xvii) audiology services and hearing aids;

(xviii) podiatry services;

(xix) chiropractic services;

(xx) immunizations;

(xxi) vision services and eyeglasses;

(xxii) waiver services;

(xxiii) individualized education programs; or

(xxiv) chemical dependency treatment.

(3) Notwithstanding clauses (1) and (2), the commissioner may authorize payment for alternative services, including, but not limited to, long-term care services, that would not otherwise be paid for under this section if the commissioner determines that the alternative services, if provided, would be a lower cost alternative to utilization of emergency room, inpatient, and other services. The commissioner shall seek a waiver or federal approval as necessary to implement this clause.

(i) Beginning July 1, 2009, pregnant noncitizens who are undocumented, nonimmigrants, or lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and 60 days postpartum, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program.

(j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance.

Sec. 5. Minnesota Statutes 2012, section 256B.06, is amended by adding a subdivision to read:

Subd. 6. **Health care for uninsured persons.** (a) Persons who are eligible for payment under subdivision 4, paragraphs (e) and (f), are eligible to enroll in a coverage program administered by the commissioner through which payment will be made to enrolled providers for the services authorized in subdivision 4, and also the services listed below that are medically necessary for treatment of an emergency medical condition as defined in subdivision 4, paragraph (g), to the extent these services are not otherwise covered pursuant to subdivision 4:

(1) hospital emergency department services;

(2) inpatient and outpatient hospital services;

(3) dialysis;

(4) chemotherapy;

(5) physician services;

(6) federally qualified health center services;

(7) rural health clinic services;

(8) nursing facility services;

(9) home and community-based waiver services;

(10) dental services;

(11) prescription drugs and pharmacy services;

(12) mental health services; and

(13) care coordination provided by a certified home health care .....

(b) In addition to services that are covered under subdivision 4 and paragraph (a), the commissioner may authorize payment for the following additional services if determined by the commissioner to be medically necessary for the treatment of an emergency medical condition after a case review process administered by the commissioner:

(1) case management for seriously and persistently mentally ill persons and for children with serious emotional disturbances;

(2) case management and directly observed therapy for people with tuberculosis;

(3) chiropractor services;

(4) clinic services;

(5) community paramedic services;

(6) other diagnostic, screening, and preventive services;

(7) emergency hospital services;

(8) extended services to women;

(9) hearing aids;

(10) hospice care;

(11) individual education plan (IEP) services provided by a school district to disabled students;

(12) some services for residents of institutions for mental diseases (IMDs);

(13) inpatient psychiatric facility services for persons under age 22;

(14) intermediate care facility services, including services provided in an intermediate care facility for persons with developmental disabilities (ICF/DD);

(15) medical equipment and supplies;

(16) medical transportation services;

(17) nurse anesthetist services;

(18) occupational therapy services;

(19) personal care assistant services;

(20) pharmacy services;

(21) physical therapy services;

(22) podiatry services;

(23) private duty nursing services;

(24) prosthetics and orthotics;

(25) public health nursing services;

(26) rehabilitation services, including day treatment for mental illness;

(27) speech therapy services; and

(28) vision care services and eyeglasses.

(c) The services covered under paragraphs (a) and (b) are covered whether or not the patient previously was treated in an emergency department or inpatient hospital for the emergency medical condition, if the services are medically necessary for the treatment of an emergency medical condition and the absence of the services could reasonably be expected to result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

(d) The commissioner may contract with a health plan, provider network, nonprofit coverage program, county or group of counties, or health care delivery system established under sections 256B.0755 and 256B.0756 to administer the coverage program authorized under this subdivision, and may delegate to the contractor the responsibility to perform case reviews and authorize payment. The commissioner may contract under this paragraph on a capitated or fixed budget basis under which the contractor is responsible for providing the covered services to eligible persons within the limits of the capitation or payment amount. The commissioner may also contract using gain-sharing and risk-sharing methods authorized for demonstration projects established under sections 256B.0755 and 256B.0756. If the commissioner contracts on a capitated, fixed fee payment, or gain-sharing or risk-sharing method, the commissioner may withhold up to five percent of the payment amount, to be paid only if the contractor achieves standards for quality and cost that are comparable to those required of health care delivery system projects under sections 256B.0755 and 256B.0756. The commissioner may separate nursing facility services and pharmacy services from other covered services in order to provide payment for these services under the commissioner's fee-for-service payment system instead of payment to the contracted entity. The commissioner may administer the program through a fee-for-service payment system without a health plan, provider network, coverage program, county or group of counties, or health care delivery system in rural areas and other regions where these options are not feasible or appropriate.

(e) The commissioner shall seek federal financial participation on all services covered under subdivision 4 and this subdivision to the extent permitted under federal law. Services for which federal financial participation is not available shall be paid for through state appropriations provided for this purpose.

(f) Coverage under this subdivision shall be authorized by the commissioner to the extent that appropriations made for this purpose are sufficient to cover all services. If appropriations are not sufficient to cover all services, the commissioner may exclude certain services from coverage or limit the number of persons eligible to receive payment for certain services, or both.

Sec. 6. Minnesota Statutes 2012, section 256B.0625, is amended by adding a subdivision to read:

Subd. 61. **Payment for multiple services provided on the same day.** The commissioner shall not prohibit payment, including supplemental payments, for mental health services or dental services provided to a patient by a clinic or health care professional solely because the mental health or dental services were provided on the same day as other covered health services furnished by the same provider.

Sec. 7. Minnesota Statutes 2012, section 256B.0651, is amended by adding a subdivision to read:

Subd. 18. **Critical access home care services payment rate.** Effective for home care services delivered on or after July 1, 2013, the commissioner shall increase reimbursements for home care service providers designated by the commissioner to be critical access home care providers by 30 percent above the reimbursement rate that would otherwise be paid to the critical access home care provider. The commissioner shall pay the managed care plans and county-based purchasing plans in an amount sufficient to reflect increased reimbursement to critical access home care providers as approved by the commissioner. The commissioner shall designate a home care provider to be a critical access home care provider if more than 50 percent of the provider's home care patient encounters per year are with patients who are low-income and uninsured or covered by medical assistance or MinnesotaCare.

Sec. 8. Minnesota Statutes 2012, section 256B.0651, is amended by adding a subdivision to read:

Subd. 19. **Critical access provider payment rates.** Payments for covered services provided under the MinnesotaCare program shall include critical access and community

health center payment rates and enhancements and special rate methodologies established under sections 256B.0625, subdivision 30; 256B.0651, subdivision 18; 256B.76, subdivision 4; and 256B.763.

Sec. 9. Minnesota Statutes 2012, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall increase reimbursement by ~~30~~ 40 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) city or county owned and operated hospital-based dental clinics;

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance, general assistance medical care, or MinnesotaCare; ~~and~~

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system~~.~~; and

(6) privately owned dental clinics or practices, if:

(i) the clinic or practice is located within a dental professional shortage area under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E, and is located outside the seven-county metropolitan area;

(ii) more than 50 percent of the clinic or practice's patient encounters per year are with patients who are low-income and uninsured or covered by medical assistance or MinnesotaCare; and

(iii) the level of service provided by the clinic or practice is critical to maintaining adequate levels of patient access within the service area in which the dentist operates.

(c) The commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) A designated critical access clinic shall receive the reimbursement rate specified in paragraph (a) for dental services provided off site at a private dental office if the following requirements are met:

(1) the designated critical access dental clinic is located within a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E, and is located outside the seven-county metropolitan area;

(2) the designated critical access dental clinic is not able to provide the service and refers the patient to the off-site dentist;

(3) the service, if provided at the critical access dental clinic, would be reimbursed at the critical access reimbursement rate;

(4) the dentist and allied dental professionals providing the services off site are licensed and in good standing under chapter 150A;

(5) the dentist providing the services is enrolled as a medical assistance provider;

(6) the critical access dental clinic submits the claim for services provided off site and receives the payment for the services; and

(7) the critical access dental clinic maintains dental records for each claim submitted under this paragraph, including the name of the dentist, the off-site location, and the license number of the dentist and allied dental professionals providing the services.

Sec. 10. Minnesota Statutes 2012, section 256B.76, is amended by adding a subdivision to read:

Subd. 7. **Teledentistry and mobile services.** Covered dental services provided remotely using telecommunications equipment or provided in settings outside of a dental clinic using portable or mobile dental equipment shall be reimbursed at the same rate as if the service were provided in-person or in a dental clinic.

Sec. 11. Minnesota Statutes 2012, section 256B.763, is amended to read:

256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.

(a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

(2) community mental health centers under section 256B.0625, subdivision 5; and

(3) mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments that are designated as essential community providers under section 62Q.19.

(b) This increase applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

(c) This increase does not apply to rates that are governed by section 256B.0625, subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

(d) The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in paragraphs (a), (e), and (f). The prepaid health plan must pass this rate increase to the providers identified in paragraphs (a), (e), (f), and (g).

(e) Payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007, for:

(1) medication education services provided on or after January 1, 2008, by adult rehabilitative mental health services providers certified under section 256B.0623; and

(2) mental health behavioral aide services provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943

and not already included in paragraph (a), payment rates shall be increased by 23.7 percent over the rates in effect on December 31, 2007.

(g) Payment rates shall be increased by 2.3 percent over the rates in effect on December 31, 2007, for individual and family skills training provided on or after January 1, 2008, by children's therapeutic services and support providers certified under section 256B.0943.

(h) In addition to increases provided under paragraphs (a) through (g), payment rates shall be increased by ten percent for services rendered on or after July 1, 2013, by community mental health centers under section 256B.0625, subdivision 5.

(i) In addition to the rate increase authorized in section 256B.763, payment rates for services rendered on or after January 1, 2014, shall be increased by ten percent over the rate in effect on December 31, 2013, for services by psychiatrists and advanced practice registered nurses with a mental health specialty delivered by community mental health centers as defined in section 256B.0625, subdivision 5, or by essential community providers who are licensed or certified as mental health providers under section 256B.0623, 256B.0943, or Minnesota Rules, parts 9520.0750 to 9520.0870.

Sec. 12. **OUTREACH AND ENROLLMENT ASSISTANCE.**

For the biennium ending June 30, 2015, the payment for outreach and enrollment assistance services resulting in a successful enrollment in medical assistance or MinnesotaCare is $250.

Sec. 13. **FEDERALLY QUALIFIED HEALTH CENTER SUBSIDY.**

For the biennium ending June 30, 2015, $5,000,000 per year is appropriated from the general fund to the commissioner of health for subsidies for federally qualified health centers under Minnesota Statutes, section 145.9269.

Sec. 14. **MEDICAL EDUCATION AND RESEARCH COSTS.**

For the biennium ending June 30, 2015, $..... per year is appropriated from the general fund to the commissioner of health for distribution under Minnesota Statutes, section 62J.692, subdivision 4.

Sec. 15. **HEALTH DISPARITIES PAYMENT ENHANCEMENT.**

The commissioner of human services shall develop a methodology to pay a higher payment rate for health care providers and services that takes into consideration the higher cost, complexity, and resources needed to serve patients and populations who experience

the greatest health disparities in order to achieve the same health and quality outcomes that are achieved for other patients and populations. The commissioner shall submit a report and recommendations to the legislature by December 15, 2013, including the proposed methodology for providing a health disparities payment adjustment.

Sec. 16. **APPROPRIATION.**

$..... for the fiscal year ending June 30, 2014, and $..... for the fiscal year ending June 30, 2015, are appropriated from the health care access fund to the commissioner of human services for purposes of Minnesota Statutes, section 256B.06, subdivisions 4 and 6.