State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH SESSION

HOUSE FILE NO. 1832

March 18, 2009
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The bill was read for the first time and referred to the Committee on Health Care and Human Services Policy and Oversight
March 26, 2009
Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Finance

A bill for an act

relating to human services; modifying the state medical review team process; requiring selection of health care homes for certain program enrollees; requiring a MinnesotaCare application coordinator; requiring an annual report; appropriating money; amending Minnesota Statutes 2008, sections 256.01, by adding a subdivision; 256B.055, subdivision 7; 256B.057, subdivision 9; 256B.0751, subdivision 7; 256L.05, subdivision 4.

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

Section 1. Minnesota Statutes 2008, section 256.01, is amended by adding a subdivision to read:

Subd. 29. **State medical review team.** (a) The commissioner shall assist applicants for medical assistance under sections 256B.055, subdivisions 7 and 12, and 256B.057, subdivision 9, who request a determination of disability, to promptly obtain all necessary documentation to support the application, including electronic medical records.

(b) The commissioner shall review all requests from the state medical review team for additional information from applicants and ensure that applicants are only required to provide medical evidence that is necessary and appropriate to a state medical review team determination.

(c) The commissioner shall provide the chairs of the legislative committees with jurisdiction over health and human services finance and budget the following information on the activities of the state medical review team by February 1, 2010, and annually thereafter:

(1) the number of applications to the state medical review team that were denied, approved, or withdrawn;

(2) the average length of time from receipt of the application to a decision;

(3) the number of appeals and appeal results;

(4) for applicants, their age, health coverage at the time of application, hospitalization history within three months of application, and whether an application for Social Security or Supplemental Security Income benefits is pending; and

(5) specific information on the medical certification, licensure, or other credentials of the person or persons performing the medical review determinations and length of time in that position.

Sec. 2. Minnesota Statutes 2008, section 256B.055, subdivision 7, is amended to read:

Subd. 7. **Aged, blind, or disabled persons.** (a) Medical assistance may be paid for a person who meets the categorical eligibility requirements of the supplemental security income program or, who would meet those requirements except for excess income or assets, and who meets the other eligibility requirements of this section.

(b) Following a determination that the applicant is not aged or blind and does not meet any other category of eligibility for medical assistance and has not been determined disabled by the Social Security Administration, applicants under this subdivision shall be referred to the commissioner's state medical review team for a determination of disability. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

Sec. 3. Minnesota Statutes 2008, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) meets the definition of disabled under the supplemental security income program;

(2) is at least 16 but less than 65 years of age;

(3) meets the asset limits in paragraph (c); and

(4) effective November 1, 2003, pays a premium and other obligations under paragraph (e).

Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

(b) After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, may retain eligibility for up to four calendar months; or

(2) effective January 1, 2004, loses employment for reasons not attributable to the enrollee, may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(c) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans; and

(3) medical expense accounts set up through the person's employer.

(d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a $65 earned income disregard. To be eligible, a person applying for medical assistance under this subdivision must have earned income above the disregard level.

(2) Effective January 1, 2004, to be considered earned income, Medicare, Social Security, and applicable state and federal income taxes must be withheld. To be eligible, a person must document earned income tax withholding.

(e)(1) A person whose earned and unearned income is equal to or greater than 100 percent of federal poverty guidelines for the applicable family size must pay a premium to be eligible for medical assistance under this subdivision. The premium shall be based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines. Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for medical assistance under this subdivision. An enrollee shall pay the greater of a $35 premium or the premium calculated in clause (1).

(3) Effective November 1, 2003, all enrollees who receive unearned income must pay one-half of one percent of unearned income in addition to the premium amount.

(4) Effective November 1, 2003, for enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner must reimburse the enrollee for Medicare Part B premiums under section 256B.0625, subdivision 15, paragraph (a).

(5) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(f) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

(j) Following a determination that the applicant is not aged or blind and does not meet any other category of eligibility for medical assistance and has not been determined disabled by the Social Security Administration, applicants under this subdivision shall be referred to the commissioner's state medical review team for a determination of disability. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

Sec. 4. Minnesota Statutes 2008, section 256B.0751, subdivision 7, is amended to read:

Subd. 7. **Outreach.** Beginning July 1, 2009, the commissioner shall ~~encourage~~ require state health care program enrollees who have a complex or chronic condition to select a primary care clinic with clinicians who have been certified as health care homes,

if there are two or more primary care clinics with clinicians who have been certified as health care homes available to the enrollee.

Sec. 5. Minnesota Statutes 2008, section 256L.05, subdivision 4, is amended to read:

Subd. 4. **Application processing.** (a) The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than 30 days from the date that the application is received by the Department of Human Services. Beginning January 1, 2000, this requirement also applies to local county human services agencies that determine eligibility for MinnesotaCare.

(b) Upon receiving an application, the commissioner or local county human services agency shall assign one individual as the coordinator of the application. The coordinator shall be responsible for all communications with the applicant throughout the application process and upon renewal.

Sec. 6. **FEDERAL APPROVAL.**

The commissioner of human services shall seek federal approval, if necessary, to implement Minnesota Statutes, section 256B.0751, subdivision 7.

Sec. 7. **APPROPRIATIONS.**

(a) $..... is appropriated from the general fund to the commissioner of human services for the biennium beginning July 1, 2009, for the purposes of Minnesota Statutes, section 256.01, subdivision 29, paragraph (a).

(b) $..... is appropriated from the general fund to the commissioner of human services for the biennium beginning July 1, 2009, for the purposes of Minnesota Statutes, section 256.01, subdivision 29, paragraph (b).