A bill for an act

relating to human services; amending health care eligibility provisions for medical assistance, MinnesotaCare, and general assistance medical care; establishing a Drug Utilization Review Board; authorizing rulemaking; requiring a report; amending Minnesota Statutes 2008, sections 62J.2930, subdivision 3; 245.494, subdivision 3; 256.015, subdivision 7; 256.969, subdivision 3a; 256B.037, subdivision 5; 256B.056, subdivisions 1c, 3c, 6; 256B.0625, by adding subdivisions; 256B.094, subdivision 3; 256B.195, subdivisions 1, 2, 3; 256B.199; 256B.69, subdivision 5a; 256B.77, subdivision 13; 256D.03, subdivision 3; 256L.01, by adding a subdivision; 256L.03, subdivision 5; 256L.15, subdivision 2; 507.092, by adding a subdivision; Laws 2005, First Special Session chapter 4, article 8, sections 54; 61; 63; 66; 74; repealing Minnesota Statutes 2008, sections 256B.031; 256L.01, subdivision 4; Laws 2005, First Special Session chapter 4, article 8, sections 21; 22; 23; 24.

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

Section 1. Minnesota Statutes 2008, section 62J.2930, subdivision 3, is amended to read:

Subd. 3. **Consumer information.** (a) The information clearinghouse or another entity designated by the commissioner shall provide consumer information to health plan company enrollees to:

(1) assist enrollees in understanding their rights;

(2) explain and assist in the use of all available complaint systems, including internal complaint systems within health carriers, community integrated service networks, and the Departments of Health and Commerce;

(3) provide information on coverage options in each region of the state;

(4) provide information on the availability of purchasing pools and enrollee subsidies; and

(5) help consumers use the health care system to obtain coverage.

(b) The information clearinghouse or other entity designated by the commissioner for the purposes of this subdivision shall not:

(1) provide legal services to consumers;

(2) represent a consumer or enrollee; or

(3) serve as an advocate for consumers in disputes with health plan companies.

(c) Nothing in this subdivision shall interfere with the ombudsman program established under section ~~256B.031, subdivision 6~~ 256B.69, subdivision 20, or other existing ombudsman programs.

Sec. 2. Minnesota Statutes 2008, section 245.494, subdivision 3, is amended to read:

Subd. 3. **Duties of the commissioner of human services.** The commissioner of human services, in consultation with the Integrated Fund Task Force, shall:

(1) in the first quarter of 1994, in areas where a local children's mental health collaborative has been established, based on an independent actuarial analysis, identify all medical assistance and MinnesotaCare resources devoted to mental health services for children in the target population including inpatient, outpatient, medication management, services under the rehabilitation option, and related physician services in the total health capitation of prepaid plans under contract with the commissioner to provide medical assistance services under section 256B.69;

(2) assist each children's mental health collaborative to determine an actuarially feasible operational target population;

(3) ensure that a prepaid health plan that contracts with the commissioner to provide medical assistance or MinnesotaCare services shall pass through the identified resources to a collaborative or collaboratives upon the collaboratives meeting the requirements of section 245.4933 to serve the collaborative's operational target population. The commissioner shall, through an independent actuarial analysis, specify differential rates the prepaid health plan must pay the collaborative based upon severity, functioning, and other risk factors, taking into consideration the fee-for-service experience of children excluded from prepaid medical assistance participation;

(4) ensure that a children's mental health collaborative that enters into an agreement with a prepaid health plan under contract with the commissioner shall accept medical assistance recipients in the operational target population on a first-come, first-served basis up to the collaborative's operating capacity or as determined in the agreement between the collaborative and the commissioner;

(5) ensure that a children's mental health collaborative that receives resources passed through a prepaid health plan under contract with the commissioner shall be subject to

the quality assurance standards, reporting of utilization information, standards set out in sections 245.487 to 245.4889, and other requirements established in Minnesota Rules, part 9500.1460;

(6) ensure that any prepaid health plan that contracts with the commissioner, including a plan that contracts under section 256B.69, must enter into an agreement with any collaborative operating in the same service delivery area that:

(i) meets the requirements of section 245.4933;

(ii) is willing to accept the rate determined by the commissioner to provide medical assistance services; and

(iii) requests to contract with the prepaid health plan;

(7) ensure that no agreement between a health plan and a collaborative shall terminate the legal responsibility of the health plan to assure that all activities under the contract are carried out. The agreement may require the collaborative to indemnify the health plan for activities that are not carried out;

(8) ensure that where a collaborative enters into an agreement with the commissioner to provide medical assistance and MinnesotaCare services a separate capitation rate will be determined through an independent actuarial analysis which is based upon the factors set forth in clause (3) to be paid to a collaborative for children in the operational target population who are eligible for medical assistance but not included in the prepaid health plan contract with the commissioner;

(9) ensure that in counties where no prepaid health plan contract to provide medical assistance or MinnesotaCare services exists, a children's mental health collaborative that meets the requirements of section 245.4933 shall:

(i) be paid a capitated rate, actuarially determined, that is based upon the collaborative's operational target population;

(ii) accept medical assistance or MinnesotaCare recipients in the operational target population on a first-come, first-served basis up to the collaborative's operating capacity or as determined in the contract between the collaborative and the commissioner; and

(iii) comply with quality assurance standards, reporting of utilization information, standards set out in sections 245.487 to 245.4889, and other requirements established in Minnesota Rules, part 9500.1460;

(10) subject to federal approval, in the development of rates for local children's mental health collaboratives, the commissioner shall consider, and may adjust, trend and utilization factors, to reflect changes in mental health service utilization and access;

(11) consider changes in mental health service utilization, access, and price, and determine the actuarial value of the services in the maintenance of rates for local children's mental health collaborative provided services, subject to federal approval;

(12) provide written notice to any prepaid health plan operating within the service delivery area of a children's mental health collaborative of the collaborative's existence within 30 days of the commissioner's receipt of notice of the collaborative's formation;

(13) ensure that in a geographic area where both a prepaid health plan including those established under either section 256B.69 or 256L.12 and a local children's mental health collaborative exist, medical assistance and MinnesotaCare recipients in the operational target population who are enrolled in prepaid health plans will have the choice to receive mental health services through either the prepaid health plan or the collaborative that has a contract with the prepaid health plan, according to the terms of the contract;

(14) develop a mechanism for integrating medical assistance resources for mental health service with MinnesotaCare and any other state and local resources available for services for children in the operational target population, and develop a procedure for making these resources available for use by a local children's mental health collaborative;

(15) gather data needed to manage mental health care including evaluation data and data necessary to establish a separate capitation rate for children's mental health services if that option is selected;

(16) by January 1, 1994, develop a model contract for providers of mental health managed care that meets the requirements set out in sections 245.491 to 245.495 and 256B.69, and utilize this contract for all subsequent awards, and before January 1, 1995, the commissioner of human services shall not enter into or extend any contract for any prepaid plan that would impede the implementation of sections 245.491 to 245.495;

(17) develop revenue enhancement or rebate mechanisms and procedures to certify expenditures made through local children's mental health collaboratives for services including administration and outreach that may be eligible for federal financial participation under medical assistance and other federal programs;

(18) ensure that new contracts and extensions or modifications to existing contracts under section 256B.69 do not impede implementation of sections 245.491 to 245.495;

(19) provide technical assistance to help local children's mental health collaboratives certify local expenditures for federal financial participation, using due diligence in order to meet implementation timelines for sections 245.491 to 245.495 and recommend necessary legislation to enhance federal revenue, provide clinical and management flexibility, and otherwise meet the goals of local children's mental health collaboratives and request

necessary state plan amendments to maximize the availability of medical assistance for activities undertaken by the local children's mental health collaborative;

(20) take all steps necessary to secure medical assistance reimbursement under the rehabilitation option for family community support services and therapeutic support of foster care and for individualized rehabilitation services;

(21) provide a mechanism to identify separately the reimbursement to a county for child welfare targeted case management provided to children served by the local collaborative for purposes of subsequent transfer by the county to the integrated fund;

(22) ensure that family members who are enrolled in a prepaid health plan and whose children are receiving mental health services through a local children's mental health collaborative file complaints about mental health services needed by the family members, the commissioner shall comply with section ~~256B.031, subdivision 6~~ 256B.69, subdivision 20. A collaborative may assist a family to make a complaint; and

(23) facilitate a smooth transition for children receiving prepaid medical assistance or MinnesotaCare services through a children's mental health collaborative who become enrolled in a prepaid health plan.

Sec. 3. Minnesota Statutes 2008, section 256.015, subdivision 7, is amended to read:

Subd. 7. **Cooperation with information requests required.** (a) Upon the request of the ~~Department~~ commissioner of human services~~,~~:

(1) any state agency or third party payer shall cooperate ~~with the department in~~ by furnishing information to help establish a third party liability~~. Upon the request of the Department of Human Services or county child support or human service agencies~~, as required by the federal Deficit Reduction Act of 2005, Public Law 109-171;

(2) any employer or third party payer shall cooperate ~~in~~ by furnishing a data file containing information about group health insurance ~~plans~~ plan or medical benefit ~~plans available to~~ plan coverage of its employees or insureds within 60 days of the request.

(b) For purposes of section 176.191, subdivision 4, the ~~Department~~ commissioner of labor and industry may allow the ~~Department~~ commissioner of human services and county agencies direct access and data matching on information relating to workers' compensation claims in order to determine whether the claimant has reported the fact of a pending claim and the amount paid to or on behalf of the claimant to the ~~Department~~ commissioner of human services.

(c) For the purpose of compliance with section 169.09, subdivision 13, and federal requirements under Code of Federal Regulations, title 42, section 433.138(d)(4), the commissioner of public safety shall provide accident data as requested by the

commissioner of human services. The disclosure shall not violate section 169.09, subdivision 13, paragraph (d).

(d) The ~~Department~~ commissioner of human services and county agencies shall limit its use of information gained from agencies, third party payers, and employers to purposes directly connected with the administration of its public assistance and child support programs. The provision of information by agencies, third party payers, and employers to the department under this subdivision is not a violation of any right of confidentiality or data privacy.

Sec. 4. Minnesota Statutes 2008, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data

to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after ~~July~~ August 1, 2005, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 6.0 percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical assistance does not include general assistance medical care. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2006, to reflect this reduction.

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

(f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2010, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this

paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2009, through June 30, 2010, to reflect this reduction.

(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2010, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2010, to reflect this reduction.

Sec. 5. Minnesota Statutes 2008, section 256B.037, subdivision 5, is amended to read:

Subd. 5. **Other contracts permitted.** Nothing in this section prohibits the commissioner from contracting with an organization for comprehensive health services, including dental services, under ~~section 256B.031,~~ sections 256B.035, 256B.69, or 256D.03, subdivision 4, paragraph (c).

Sec. 6. Minnesota Statutes 2008, section 256B.056, subdivision 1c, is amended to read:

Subd. 1c. **Families with children income methodology.** (a)(1) [Expired, 1Sp2003 c 14 art 12 s 17]

(2) For applications processed within one calendar month prior to July 1, 2003, eligibility shall be determined by applying the income standards and methodologies in effect prior to July 1, 2003, for any months in the six-month budget period before July 1, 2003, and the income standards and methodologies in effect on July 1, 2003, for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(3) For children ages one through 18 whose eligibility is determined under section 256B.057, subdivision 2, the following deductions shall be applied to income counted toward the child's eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: $90 work expense, dependent care, and child support paid under court order. This clause is effective October 1, 2003.

(b) For families with children whose eligibility is determined using the standard specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable earned income shall be disregarded for up to four months and the following deductions shall be applied to each individual's income counted toward eligibility as allowed under

the state's AFDC plan in effect as of July 16, 1996: dependent care and child support paid under court order.

(c) If the four-month disregard in paragraph (b) has been applied to the wage earner's income for four months, the disregard shall not be applied again until the wage earner's income has not been considered in determining medical assistance eligibility for 12 consecutive months.

(d) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

(e) For children age 18 or under, annual gifts of $2,000 or less by a tax-exempt organization to or for the benefit of the child with a life-threatening illness must be disregarded from income.

Sec. 7. Minnesota Statutes 2008, section 256B.056, subdivision 3c, is amended to read:

Subd. 3c. **Asset limitations for families and children.** A household of two or more persons must not own more than $20,000 in total net assets, and a household of one person must not own more than $10,000 in total net assets. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business up to $200,000 are not considered;

(3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;

(4) ~~one burial plot and all other burial expenses equal to the supplemental security income program asset limit are not considered for each individual~~ assets designated as burial expenses are excluded to the same extent they are excluded by the Supplemental Security Income program;

(5) court-ordered settlements up to $10,000 are not considered;

(6) individual retirement accounts and funds are not considered; and

(7) assets owned by children are not considered.

Sec. 8. Minnesota Statutes 2008, section 256B.056, subdivision 6, is amended to read:

Subd. 6. **Assignment of benefits.** To be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person or the person's legal representative from any third party liable for the costs of medical care. By accepting or receiving assistance, the person is deemed to have assigned the person's rights to medical support and third party payments as required by title 19 of the Social Security Act. Persons must cooperate with the state in establishing paternity and obtaining third party payments. By accepting medical assistance, a person assigns to the Department of Human Services all rights the person may have to medical support or payments for medical expenses from any other person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. Any rights or amounts so assigned shall be applied against the cost of medical care paid for under this chapter. Any assignment takes effect upon the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant is determined eligible for and receives medical assistance benefits. The application must contain a statement explaining this assignment. For the purposes of this section, "the Department of Human Services or the state" includes prepaid health plans under contract with the commissioner according to sections ~~256B.031,~~ 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing facilities under the alternative payment demonstration project under section 256B.434; and the county-based purchasing entities under section 256B.692.

Sec. 9. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13i. **Drug Utilization Review Board; report.** (a) A nine-member Drug Utilization Review Board is established. The board must be comprised of at least three but no more than four licensed physicians actively engaged in the practice of medicine in Minnesota; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative. The remainder must be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the board must be appointed by the commissioner, shall serve three-year terms, and may be reappointed by the commissioner. The board shall annually elect a chair from among its members.

(b) The board must be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the board.

(c) The commissioner shall, with the advice of the board:

(1) implement a medical assistance retrospective and prospective drug utilization review program as required by United States Code, title 42, section 1396r-8(g)(3);

(2) develop and implement the predetermined criteria and practice parameters for appropriate prescribing to be used in retrospective and prospective drug utilization review;

(3) develop, select, implement, and assess interventions for physicians, pharmacists, and patients that are educational and not punitive in nature;

(4) establish a grievance and appeals process for physicians and pharmacists under this section;

(5) publish and disseminate educational information to physicians and pharmacists regarding the board and the review program;

(6) adopt and implement procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the review program that identifies individual physicians, pharmacists, or recipients;

(7) establish and implement an ongoing process to:

(i) receive public comment regarding drug utilization review criteria and standards; and

(ii) consider the comments along with other scientific and clinical information in order to revise criteria and standards on a timely basis; and

(8) adopt any rules necessary to carry out this section.

(d) The board may establish advisory committees. The commissioner may contract with appropriate organizations to assist the board in carrying out the board's duties. The commissioner may enter into contracts for services to develop and implement a retrospective and prospective review program.

(e) The board shall report to the commissioner annually on the date the drug utilization review annual report is due to the Centers for Medicare and Medicaid Services. This report must cover the preceding federal fiscal year. The commissioner shall make the report available to the public upon request. The report must include information on the activities of the board and the program; the effectiveness of implemented interventions; administrative costs; and any fiscal impact resulting from the program. An honorarium of $100 per meeting and reimbursement for mileage must be paid to each board member in attendance.

(f) This subdivision is exempt from the provisions of section 15.059.

Sec. 10. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

Subd. 53. **Centers of excellence.** For complex medical procedures with a high degree of variation in outcomes, for which the Medicare program requires facilities providing the services to meet certain criteria as a condition of coverage, the commissioner may develop centers of excellence facility criteria in consultation with the Health Services Policy Committee, section 256B.0625, subdivision 3c. The criteria must reflect facility traits that have been linked to superior patient safety and outcomes for the procedures in question, and must be based on the best available empirical evidence. For medical assistance recipients enrolled on a fee-for-service basis, the commissioner may make coverage for these procedures conditional upon the facility providing the services meeting the specified criteria. Only facilities meeting the criteria may be reimbursed for the procedures in question.

EFFECTIVE DATE. This section is effective August 1, 2009, or upon federal approval, whichever is later.

Sec. 11. Minnesota Statutes 2008, section 256B.094, subdivision 3, is amended to read:

Subd. 3. **Coordination and provision of services.** (a) In a county or reservation where a prepaid medical assistance provider has contracted under section ~~256B.031 or~~ 256B.69 to provide mental health services, the case management provider shall coordinate with the prepaid provider to ensure that all necessary mental health services required under the contract are provided to recipients of case management services.

(b) When the case management provider determines that a prepaid provider is not providing mental health services as required under the contract, the case management provider shall assist the recipient to appeal the prepaid provider's denial pursuant to section 256.045, and may make other arrangements for provision of the covered services.

(c) The case management provider may bill the provider of prepaid health care services for any mental health services provided to a recipient of case management services which the county or tribal social services arranges for or provides and which are included in the prepaid provider's contract, and which were determined to be medically necessary as a result of an appeal pursuant to section 256.045. The prepaid provider must reimburse the mental health provider, at the prepaid provider's standard rate for that service, for any services delivered under this subdivision.

(d) If the county or tribal social services has not obtained prior authorization for this service, or an appeal results in a determination that the services were not medically

necessary, the county or tribal social services may not seek reimbursement from the prepaid provider.

Sec. 12. Minnesota Statutes 2008, section 256B.195, subdivision 1, is amended to read:

Subdivision 1. **Federal approval required.** ~~Sections~~ Section 145.9268~~, 256.969, subdivision 26,~~ and this section are contingent on federal approval of the intergovernmental transfers and payments to safety net hospitals and community clinics authorized under this section. These sections are also contingent on current payment, by the government entities, of intergovernmental transfers under section 256B.19 and this section.

Sec. 13. Minnesota Statutes 2008, section 256B.195, subdivision 2, is amended to read:

Subd. 2. **Payments from governmental entities.** (a) In addition to any payment required under section 256B.19, effective July 15, 2001, the following government entities shall make the payments indicated ~~before noon on the 15th of each month~~ annually:

(1) Hennepin County, ~~$2,000,000~~ $24,000,000; and

(2) Ramsey County, ~~$1,000,000~~ $12,000,000.

(b) These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs. Of these payments, Hennepin County shall pay 71 percent directly to Hennepin County Medical Center, and Ramsey County shall pay 71 percent directly to Regions Hospital. The counties must provide certification to the commissioner of payments to hospitals under this subdivision.

Sec. 14. Minnesota Statutes 2008, section 256B.195, subdivision 3, is amended to read:

Subd. 3. **Payments to certain safety net providers.** (a) Effective July 15, 2001, the commissioner shall make the following payments to the hospitals indicated ~~after noon on the 15th of each month~~ annually:

(1) to Hennepin County Medical Center, any federal matching funds available to match the payments received by the medical center under subdivision 2, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care; and

(2) to Regions Hospital, any federal matching funds available to match the payments received by the hospital under subdivision 2, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care.

(b) Effective July 15, 2001, the following percentages of the transfers under subdivision 2 shall be retained by the commissioner for deposit each month into the general fund:

(1) 18 percent, plus any federal matching funds, shall be allocated for the following purposes:

(i) during the fiscal year beginning July 1, 2001, of the amount available under this clause, 39.7 percent shall be allocated to make increased hospital payments under section 256.969, subdivision 26; 34.2 percent shall be allocated to fund the amounts due from small rural hospitals, as defined in section 144.148, for overpayments under section 256.969, subdivision 5a, resulting from a determination that medical assistance and general assistance payments exceeded the charge limit during the period from 1994 to 1997; and 26.1 percent shall be allocated to the commissioner of health for rural hospital capital improvement grants under section 144.148; and

(ii) during fiscal years beginning on or after July 1, 2002, of the amount available under this clause, 55 percent shall be allocated to make increased hospital payments under section 256.969, subdivision 26, and 45 percent shall be allocated to the commissioner of health for rural hospital capital improvement grants under section 144.148; and

(2) 11 percent shall be allocated to the commissioner of health to fund community clinic grants under section 145.9268.

(c) This subdivision shall apply to fee-for-service payments only and shall not increase capitation payments or payments made based on average rates. The allocation in paragraph (b), clause (1), item (ii), to increase hospital payments under section 256.969, subdivision 26, shall not limit payments under that section.

(d) Medical assistance rate or payment changes, including those required to obtain federal financial participation under section 62J.692, subdivision 8, shall precede the determination of intergovernmental transfer amounts determined in this subdivision. Participation in the intergovernmental transfer program shall not result in the offset of any health care provider's receipt of medical assistance payment increases other than limits resulting from hospital-specific charge limits and limits on disproportionate share hospital payments.

(e) Effective July 1, 2003, if the amount available for allocation under paragraph (b) is greater than the amounts available during March 2003, after any increase in intergovernmental transfers and payments that result from section 256.969, subdivision 3a, paragraph (c), are paid to the general fund, any additional amounts available under this subdivision after reimbursement of the transfers under subdivision 2 shall be allocated to

increase medical assistance payments, subject to hospital-specific charge limits and limits on disproportionate share hospital payments, as follows:

(1) if the payments under subdivision 5 are approved, the amount shall be paid to the largest ten percent of hospitals as measured by 2001 payments for medical assistance, general assistance medical care, and MinnesotaCare in the nonstate government hospital category. Payments shall be allocated according to each hospital's proportionate share of the 2001 payments; or

(2) if the payments under subdivision 5 are not approved, the amount shall be paid to the largest ten percent of hospitals as measured by 2001 payments for medical assistance, general assistance medical care, and MinnesotaCare in the nonstate government category and to the largest ten percent of hospitals as measured by payments for medical assistance, general assistance medical care, and MinnesotaCare in the nongovernment hospital category. Payments shall be allocated according to each hospital's proportionate share of the 2001 payments in their respective category of nonstate government and nongovernment. The commissioner shall determine which hospitals are in the nonstate government and nongovernment hospital categories.

Sec. 15. Minnesota Statutes 2008, section 256B.199, is amended to read:

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

(a) Effective July 1, 2007, the commissioner shall apply for federal matching funds for the expenditures in paragraphs (b) and (c).

(b) The commissioner shall apply for federal matching funds for certified public expenditures as follows:

(1) Hennepin County, Hennepin County Medical Center, Ramsey County, Regions Hospital, the University of Minnesota, and Fairview-University Medical Center shall report ~~quarterly~~ annually to the commissioner beginning June 1, 2007, payments made during the ~~second~~ previous ~~quarter~~ calendar year that may qualify for reimbursement under federal law;

(2) based on these reports, the commissioner shall apply for federal matching funds. These funds are appropriated to the commissioner for the payments under section 256.969, subdivision 27; and

(3) by May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share hospital payment money expected to be available in the current federal fiscal year.

(c) The commissioner shall apply for federal matching funds for general assistance medical care expenditures as follows:

(1) for hospital services occurring on or after July 1, 2007, general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be used to apply for federal matching funds, except as limited below:

(i) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and

(ii) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act; and

(2) all hospitals must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures.

Sec. 16. Minnesota Statutes 2008, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and sections 256L.12 and 256D.03, shall be entered into or renewed on a calendar year basis beginning January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B, 256D, and 256L, is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B, 256D, and 256L, established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section for the prepaid medical assistance and general assistance medical care programs pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The

performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23. A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

(d)(1) Effective for services rendered on or after January 1, 2009, the commissioner shall withhold three percent of managed care plan payments under this section for the prepaid medical assistance and general assistance medical care programs. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(2) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph. The return of the withhold under this paragraph is not subject to the requirements of paragraph (c).

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

Sec. 17. Minnesota Statutes 2008, section 256B.77, subdivision 13, is amended to read:

Subd. 13. **Ombudsman.** Enrollees shall have access to ombudsman services established in section ~~256B.031, subdivision 6~~ 256B.69, subdivision 20, and advocacy services provided by the ombudsman for mental health and developmental disabilities established in sections 245.91 to 245.97. The managed care ombudsman and the ombudsman for mental health and developmental disabilities shall coordinate services provided to avoid duplication of services. For purposes of the demonstration project, the powers and responsibilities of the Office of Ombudsman for Mental Health and Developmental Disabilities, as provided in sections 245.91 to 245.97 are expanded to include all eligible individuals, health plan companies, agencies, and providers participating in the demonstration project.

Sec. 18. Minnesota Statutes 2008, section 256D.03, subdivision 3, is amended to read:

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare ~~as~~ for applicants and recipients defined in paragraph ~~(b)~~ (c), except as provided in paragraph ~~(c)~~ (d), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of $1,000 per assistance unit. General assistance medical care is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify their assets. Enrollees who become eligible for medical assistance shall be terminated and transferred to medical assistance. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; or

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization~~; or~~.

~~(iii)~~ (b) the commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

~~(b)~~ (c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph ~~(c)~~ (f).

~~(c)~~ (d) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance

medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month general assistance medical care eligibility period, until their six-month renewal.

~~(d)~~ (e) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph ~~(c)~~ (d), an individual must complete a new application.

~~(e)~~ (f) Applicants and recipients eligible under paragraph (a), clause ~~(1)~~ (2), item (i), are exempt from the MinnesotaCare enrollment requirements in this subdivision if they:

(1) have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration;

(2) fail to meet the requirements of section 256L.09, subdivision 2;

(3) are homeless as defined by United States Code, title 42, section 11301, et seq.;

(4) are classified as end-stage renal disease beneficiaries in the Medicare program;

(5) are enrolled in private health care coverage as defined in section 256B.02, subdivision 9;

(6) are eligible under paragraph ~~(j)~~ (k);

(7) receive treatment funded pursuant to section 254B.02; or

(8) reside in the Minnesota sex offender program defined in chapter 246B.

~~(f)~~ (g) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization.

~~(g)~~ (h) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph ~~(c)~~ (d) and submitted to the county agency shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraphs ~~(c)~~ (d), ~~(e)~~ (f), and ~~(f)~~ (g).

~~(h)~~ (i) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5, and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

~~(i)~~ (j) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

~~(j)~~ (k) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

~~(k)~~ (l) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

~~(l)~~ (m) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this

paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

~~(m)~~ (n) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

~~(n)~~ (o) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services.

~~(o)~~ (p) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

~~(p)~~ (q) Effective July 1, 2003, general assistance medical care emergency services end.

Sec. 19. Minnesota Statutes 2008, section 256L.01, is amended by adding a subdivision to read:

Subd. 4a. **Gross individual or gross family income.** "Gross individual or gross family income" means:

(1) for nonfarm self-employed, income calculated for the 12-month period of eligibility using, as a baseline, the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in depreciation and carryover net operating loss amounts that apply to the business in which the family is currently engaged;

(2) for farm self-employed, income calculated for the 12-month period of eligibility using, as the baseline, the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in reported depreciation amounts that apply to the business in which the family is currently engaged; and

(3) the total income for all family members, calculated for the 12-month period of eligibility.

EFFECTIVE DATE. This section is effective August 1, 2009.

Sec. 20. Minnesota Statutes 2008, section 256L.03, subdivision 5, is amended to read:

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

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

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist; and

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

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

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

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

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

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

Sec. 21. Minnesota Statutes 2008, section 256L.15, subdivision 2, is amended to read:

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

(b) Children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

(c) Beginning July 1, 2009, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d) with the exception that children in families with income at or below 150 percent of the federal poverty guidelines shall pay a monthly premium of $4. For purposes of paragraph (d), "minimum" means a monthly premium of $4.

(d) The following premium scale is established for individuals and families with gross family incomes of ~~300~~ 275 percent of the federal poverty guidelines or less:

Federal Poverty Guideline Range	Percent of Average Gross Monthly Income
0-45%	minimum
46-54%	$4 or 1.1% of family income, whichever is greater
55-81%	1.6%
82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
165-191%	4.6%
192-219%	5.6%
220-248%	6.5%
~~249-274%~~ 249-275%	7.2%
~~275-300%~~	~~8.0%~~

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

Sec. 22. Minnesota Statutes 2008, section 507.092, is amended by adding a subdivision to read:

Subd. 4. **Medical assistance liens; transfer on death deed.** (a) In counties where the district court has a probate division, actions to enforce a medical assistance lien or claim against real property described in a transfer on death deed and any matter raised in connection with enforcement shall be determined in the probate division. Notwithstanding any other law to the contrary, the provisions of section 256B.15 shall apply to any proceeding to enforce a medical assistance lien or claim under chapter 524 or 525. In other counties, the district court shall have jurisdiction to determine any matter affecting real property purporting to be transferred by a transfer on death deed.

(b) This provision is effective the day following final enactment retroactively from August 1, 2008, and applies to instruments recorded on or after August 1, 2008, and to claims, disputes, and other matters arising from or relating to such instruments, provided however that no deed or other voluntary instrument may be refused recording on or after August 1, 2008, for failure to comply with the requirements of this section or section 508.50 or 508A.50, as appropriate, if the deed or other voluntary instrument complies with this section or the requirements of this section as it existed prior to the effective date of this amendment.

Sec. 23. Laws 2005, First Special Session chapter 4, article 8, section 54, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective August 1, ~~2007, or upon HealthMatch implementation, whichever is later~~ 2009.

Sec. 24. Laws 2005, First Special Session chapter 4, article 8, section 61, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective August 1, ~~2007, or upon HealthMatch implementation, whichever is later~~ 2009.

Sec. 25. Laws 2005, First Special Session chapter 4, article 8, section 63, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective August 1, ~~2007, or upon HealthMatch implementation, whichever is later~~ 2009.

Sec. 26. Laws 2005, First Special Session chapter 4, article 8, section 66, the effective date, is amended to read:

EFFECTIVE DATE. Paragraph (a) is effective August 1, ~~2007, or upon HealthMatch implementation, whichever is later~~ 2009, and paragraph (e) is effective September 1, 2006.

Sec. 27. Laws 2005, First Special Session chapter 4, article 8, section 74, the effective date, is amended to read:

EFFECTIVE DATE. The amendment to paragraph (a) changing gross family or individual income to monthly gross family or individual income is effective August 1, ~~2007, or upon implementation of HealthMatch, whichever is later~~ 2009. The amendment to paragraph (a) related to premium adjustments and changes of income and the amendment to paragraph (c) are effective September 1, 2005, or upon federal approval, whichever is later. ~~Prior to the implementation of HealthMatch,~~ The commissioner shall implement this section to the fullest extent possible, including the use of manual processing. ~~Upon implementation of HealthMatch, the commissioner shall implement this section in a manner consistent with the procedures and requirements of HealthMatch.~~

Sec. 28. **REPEALER.**

(a) Minnesota Statutes 2008, sections 256B.031; and 256L.01, subdivision 4, are repealed.

(b) Laws 2005, First Special Session chapter 4, article 8, sections 21; 22; 23; and 24, are repealed.

EFFECTIVE DATE. This section is effective August 1, 2009.

256B.031 PREPAID HEALTH PLANS.

Subdivision 1. **Contracts.** The commissioner may contract with health insurers licensed and operating under chapters 60A and 62A, nonprofit health service plans licensed and operating under chapter 62C, health maintenance organizations licensed and operating under chapter 62D, and vendors of medical care and organizations participating in prepaid programs under section 256D.03, subdivision 4, clause (b), to provide medical services to medical assistance recipients. Notwithstanding any other law, health insurers may enter into contracts with the commissioner under this section. As a condition of the contract, health insurers and health service plan corporations must agree to comply with the requirements of section 62D.04, subdivision 1, clauses (a), (b), (c), (d), and (f), and provide a complaint procedure that satisfies the requirements of section 62D.11. Nothing in this section permits health insurers not licensed as health maintenance organizations under chapter 62D to offer a prepaid health plan as defined in section 256B.02, subdivision 12, to persons other than those receiving medical assistance or general assistance medical care under this section. Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7. Contracts must specify the services that are included in the per capita rate. Contracts must specify those services that are to be eligible for risk sharing between the prepaid health plan and the state. Contracts must also state that payment must be made within 60 days after the month of coverage.

Subd. 2. **Services.** State contracts for these services must assure recipients of at least the comprehensive health services defined in sections 256B.02, subdivision 8, and 256B.0625, except services defined in section 256B.0625, subdivisions 2, 5, 18, and 19a, and except services defined as chemical dependency services and mental health services.

Contracts under this section must include provision for assessing pregnant women to determine their risk of poor pregnancy outcome. Contracts must also include provision for treatment of women found to be at risk of poor pregnancy outcome.

Subd. 3. **Information required.** Prepaid health plans under contract must provide information to the commissioner according to the contract specifications. The information must include, at a minimum, the number of people receiving services, the number of encounters, the types of services received, evidence of an operating quality assurance program, and information about the use of and actual recoveries of available third-party resources. A plan under contract to provide services in a county must provide the county agency with the most current listing of the health care providers whose services are covered by the plan.

Subd. 4. **Prepaid health plan rates.** For payments made during calendar year 1988, the monthly maximum allowable rate established by the commissioner of human services for payment to prepaid health plans must not exceed 90 percent of the projected average monthly per capita fee-for-service medical assistance costs for state fiscal year 1988 for recipients of the aid to families with dependent children program formerly codified in sections 256.72 to 256.87. The base year for projecting the average monthly per capita fee-for-service medical assistance costs is state fiscal year 1986. A maximum allowable per capita rate must be established collectively for Anoka, Carver, Dakota, Hennepin, Ramsey, St. Louis, Scott, and Washington Counties. A separate maximum allowable per capita rate must be established collectively for all other counties. The maximum allowable per capita rate may be adjusted to reflect utilization differences among eligible classes of recipients. For payments made during calendar year 1989, the maximum allowable rate must be calculated in the same way as 1988 rates, except the base year is state fiscal year 1987. For payments made during calendar year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology. Rates established for prepaid health plans must be based on the services that the prepaid health plan provides under contract with the commissioner.

Subd. 5. **Free choice limited.** (a) The commissioner may require recipients of the Minnesota family investment program to enroll in a prepaid health plan and receive services from or through the prepaid health plan, with the following exceptions:

(1) recipients who are refugees and whose health services are reimbursed 100 percent by the federal government; and

(2) recipients who are placed in a foster home or facility. If placement occurs before the seventh day prior to the end of any month, the recipient will be disenrolled from the recipient's prepaid health plan effective the first day of the following month. If placement occurs after the seventh day before the end of any month, that recipient will be disenrolled from the prepaid health plan on the first day of the second month following placement. The prepaid health plan must provide all services set forth in subdivision 2 during the interim period.

Enrollment in a prepaid health plan is mandatory only when recipients have a choice of at least two prepaid health plans.

(b) Recipients who become eligible on or after December 1, 1987, must choose a health plan within 30 days of the date eligibility is determined. At the time of application, the local agency shall ask the recipient whether the recipient has a primary health care provider. If the recipient has not chosen a health plan within 30 days but has provided the local agency with the name of a primary health care provider, the local agency shall determine whether the provider participates in a prepaid health plan available to the recipient and, if so, the local agency shall select that plan on the recipient's behalf. If the recipient has not provided the name of a primary health care provider who participates in an available prepaid health plan, commissioner shall randomly assign the recipient to a health plan.

(c) If possible, the local agency shall ask whether the recipient has a primary health care provider and the procedures under paragraph (b) shall apply. If a recipient does not choose a prepaid health plan by this date, the commissioner shall randomly assign the recipient to a health plan.

(d) The commissioner shall request a waiver from the federal Centers for Medicare and Medicaid Services to limit a recipient's ability to change health plans to once every six or 12 months. If such a waiver is obtained, each recipient must be enrolled in the health plan for a minimum of six or 12 months. A recipient may change health plans once within the first 60 days after initial enrollment.

(e) Women who are receiving medical assistance due to pregnancy and later become eligible for the Minnesota family investment program are not required to choose a prepaid health plan until 60 days postpartum. An infant born as a result of that pregnancy must be enrolled in a prepaid health plan at the same time as the mother.

(f) If third-party coverage is available to a recipient through enrollment in a prepaid health plan through employment, through coverage by the former spouse, or if a duty of support has been imposed by law, order, decree, or judgment of a court under chapter 518A, the obligee or recipient shall participate in the prepaid health plan in which the obligee has enrolled provided that the commissioner has contracted with the plan.

Subd. 6. **Ombudsman.** The commissioner shall designate an ombudsman to advocate for persons required to enroll in prepaid health plans under this section. The ombudsman shall advocate for recipients enrolled in prepaid health plans through complaint and appeal procedures and ensure that necessary medical services are provided either by the prepaid health plan directly or by referral to appropriate social services. At the time of enrollment in a prepaid health plan, the local agency shall inform recipients about the ombudsman program and their right to a resolution of a complaint by the prepaid health plan if they experience a problem with the plan or its providers.

Subd. 7. **Services pending appeal.** If the recipient appeals in writing to the state agency on or before the tenth day after the decision of the prepaid health plan to reduce, suspend, or terminate services which the recipient had been receiving, and the treating physician or another plan physician orders the services to be continued at the previous level, the prepaid health plan must continue to provide services at a level equal to the level ordered by the plan's physician until the state agency renders its decision.

Subd. 8. **Case management.** The commissioner shall prepare a report to the legislature by January 1988, that describes the issues involved in successfully implementing a case management system in counties where the commissioner has fewer than two prepaid health plans under contract to provide health care services to eligible classes of recipients. In the report the commissioner shall address which health care providers could be case managers, the responsibilities of the case manager, the assumption of risk by the case manager, the services to be provided either directly or by referral, reimbursement concerns, federal waivers that may be required, and other issues that may affect the quality and cost of care under such a system.

Subd. 9. **Prepayment coordinator.** The local agency shall designate a prepayment coordinator to assist the state agency in implementing this section, section 256B.69, and section 256D.03, subdivision 4. Assistance must include educating recipients about available health care options, enrolling recipients under subdivision 5, providing necessary eligibility and enrollment information to health plans and the state agency, and coordinating complaints and appeals with the ombudsman established in subdivision 6.

Subd. 10. **Impact on public or teaching hospitals and community clinics.** (a) Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the

opportunity to participate in the program, provided the terms of participation in the program are competitive with the terms of other participants.

(b) Prepaid health plans serving counties with a nonprofit community clinic or community health services agency must contract with the clinic or agency to provide services to clients who choose to receive services from the clinic or agency, if the clinic or agency agrees to payment rates that are competitive with rates paid to other health plan providers for the same or similar services.

Subd. 11. **Reimbursement limitation; providers not with prepaid health plan.** A prepaid health plan may limit any reimbursement it may be required to pay to providers not employed by or under contract with the prepaid health plan to the medical assistance rates for medical assistance enrollees, and the general assistance medical care rates for general assistance medical care enrollees, paid by the commissioner of human services to providers for services to recipients not enrolled in a prepaid health plan.

256L.01 DEFINITIONS.

Subd. 4. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the 12-month period of eligibility using the net profit or loss reported on the applicant's federal income tax form for the previous year and using the medical assistance families with children methodology for determining allowable and nonallowable self-employment expenses and countable income.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the 12-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year.

(c) "Gross individual or gross family income" means the total income for all family members, calculated for the 12-month period of eligibility.

Laws 2005, First Special Session chapter 4, article 8, section 21

Sec. 21. Minnesota Statutes 2004, section 256B.056, subdivision 5, is amended to read:

Subd. 5. **Excess income.** A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 5c. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the last business day of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before noon on the last business day of the month in order to be eligible for this option in the following month.

EFFECTIVE DATE.

This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Laws 2005, First Special Session chapter 4, article 8, section 22

Sec. 22. Minnesota Statutes 2004, section 256B.056, subdivision 5a, is amended to read:

Subd. 5a. **Individuals on fixed or excluded income.** Recipients of medical assistance who receive only fixed unearned or excluded income, when that income is excluded from consideration as income or unvarying in amount and timing of receipt throughout the year, shall report and verify their income every 12 months. The 12-month period begins with the month of application.

EFFECTIVE DATE.

This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Laws 2005, First Special Session chapter 4, article 8, section 23

Sec. 23. Minnesota Statutes 2004, section 256B.056, subdivision 5b, is amended to read:

Subd. 5b. **Individuals with low income.** Recipients of medical assistance not residing in a long-term care facility who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income every six months. The six-month period begins the month of application.

EFFECTIVE DATE.

This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.

Laws 2005, First Special Session chapter 4, article 8, section 24

Sec. 24. Minnesota Statutes 2004, section 256B.056, subdivision 7, is amended to read:

Subd. 7. **Period of eligibility.** Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. Eligibility for months prior to application is determined independently from eligibility for the month of application and future months. A redetermination of eligibility must occur every 12 months. The 12-month period begins with the month of application.

EFFECTIVE DATE.

This section is effective August 1, 2007, or upon HealthMatch implementation, whichever is later.