

A bill for an act

relating to health care; establishing mental health urgent care and consultation services; modifying the general assistance medical care program; appropriating money; amending Minnesota Statutes 2008, sections 256.9657, subdivisions 2, 3; 256.969, subdivisions 21, 26, 27; 256B.0625, subdivision 13f, by adding a subdivision; 256B.69, by adding a subdivision; 256D.03, subdivisions 3a, 3b; 256D.06, subdivision 7; 256L.05, subdivisions 1b, 3, 3a; 256L.07, subdivision 6; 256L.15, subdivision 4; 256L.17, subdivision 7; Minnesota Statutes 2009 Supplement, sections 256.969, subdivisions 2b, 3a, 30; 256B.195, subdivision 3; 256D.03, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 245; 256D.

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

Section 1. **[245.4862] MENTAL HEALTH URGENT CARE AND PSYCHIATRIC CONSULTATION.**

Subdivision 1. Mental health urgent care and psychiatric consultation. The commissioner shall include mental health urgent care and psychiatric consultation services as part of, but not limited to, the redesign of six community-based behavioral health hospitals and the Anoka-Metro Regional Treatment Center. These services must not duplicate existing services in the region, and must be implemented as specified in subdivisions 3 to 7.

Subd. 2. Definitions. For purposes of this section:

(a) Mental health urgent care includes:

(1) initial mental health screening;

(2) mobile crisis assessment and intervention;

(3) rapid access to psychiatry, including psychiatric evaluation, initial treatment, and short-term psychiatry;

(4) nonhospital crisis stabilization residential beds; and

(5) health care navigator services which include, but are not limited to, assisting uninsured individuals in obtaining health care coverage.

(b) Psychiatric consultation services includes psychiatric consultation to primary care practitioners.

Subd. 3. **Rapid access to psychiatry.** The commissioner shall develop rapid access to psychiatric services based on the following criteria:

(1) the individuals who receive the psychiatric services must be at risk of hospitalization and otherwise unable to receive timely services;

(2) where clinically appropriate, the service may be provided via interactive video where the service is provided in conjunction with an emergency room, a local crisis service, or a primary care or behavioral care practitioner; and

(3) the commissioner may integrate rapid access to psychiatry with the psychiatric consultation services in subdivision 4.

Subd. 4. **Collaborative psychiatric consultation.** The commissioner shall establish a collaborative psychiatric consultation service based on the following criteria:

(1) the service may be available via telephone, interactive video, e-mail, or other means of communication to emergency rooms, local crisis services, and primary care practitioners, including pediatricians;

(2) the service shall include child and adolescent psychiatrists and adult psychiatrists;

(3) the first priority for this service is to provide the consultations required under section 256B.0625, subdivision 13j; and

(4) the service must encourage use of cognitive and behavioral therapies and other evidence-based treatments in addition to or in place of medication, where appropriate.

Subd. 5. **Phased availability.** (a) The commissioner may phase in the availability of mental health urgent care services based on the limits of appropriations and the commissioner's determination of level of need and cost-effectiveness.

(b) For subdivisions 3 and 4, the first phase must focus on adults in Hennepin and Ramsey Counties and children statewide who are affected by section 256B.0625, subdivision 13j, and must include tracking of costs for the services provided and associated impacts on utilization of inpatient, emergency room, and other services.

Subd. 6. **Limited appropriations.** The commissioner shall maximize use of available health care coverage for the services provided under this section. The commissioner's responsibility to provide these services for individuals without health care coverage must not exceed the appropriations for this section.

Subd. 7. **Flexible implementation.** To implement this section, the commissioner shall select the structure and funding method that is the most cost-effective for each county

or group of counties. This may include grants, contracts, direct provision by state-operated services, and public-private partnerships. Where feasible, the commissioner shall make any grants under this section a part of the integrated adult mental health initiative grants under section 245.4661.

Sec. 2. Minnesota Statutes 2008, section 256.9657, subdivision 2, is amended to read:

Subd. 2. Hospital surcharge. (a) Effective October 1, 1992, each Minnesota hospital except facilities of the federal Indian Health Service and regional treatment centers shall pay to the medical assistance account a surcharge equal to 1.4 percent of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.

(b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56 percent.

(c) Effective March 1, 2010, to September 30, 2010, the surcharge under paragraph (b) is increased to 3.95 percent. Effective October 1, 2010, to June 30, 2011, the surcharge under paragraph (b) is increased to 3.06 percent. Notwithstanding section 256.9656, money collected under this paragraph in excess of the amount collected under paragraph (b) shall be deposited in the account established in section 256D.032.

(d) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

EFFECTIVE DATE. This section is effective March 1, 2010.

Sec. 3. Minnesota Statutes 2008, section 256.9657, subdivision 3, is amended to read:

Subd. 3. Surcharge on HMOs and community integrated service networks. (a) Effective October 1, 1992, each health maintenance organization with a certificate of authority issued by the commissioner of health under chapter 62D and each community integrated service network licensed by the commissioner under chapter 62N shall pay to the commissioner of human services a surcharge equal to six-tenths of one percent of the total premium revenues of the health maintenance organization or community integrated service network as reported to the commissioner of health according to the schedule in subdivision 4.

(b) Effective March 1, 2010, to June 30, 2011: (1) the surcharge under paragraph (a) is increased to 4.0 percent; and (2) each county-based purchasing plan authorized under section 256B.692 shall pay to the commissioner a surcharge equal to 4.0 percent of the total premium revenues of the plan, as reported to the commissioner of health, according

to the payment schedule in subdivision 4. Notwithstanding section 256.9656, money collected under this paragraph in excess of the amount collected under paragraph (a) shall be deposited in the account established in section 256D.032.

(c) For purposes of this subdivision, total premium revenue means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a health maintenance organization or community integrated service network from the Federal Employees Health Benefit Program;

(2) premiums from Medicare wrap-around subscribers for health benefits which supplement Medicare coverage;

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization or a community integrated service network and the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services, for services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and 1395w-24, respectively, as they may be amended from time to time; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization or community integrated service network and a Medicaid state agency, for services to a medical assistance beneficiary.

If advance payments are made under clause (1) or (2) to the health maintenance organization or community integrated service network for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

~~(c)~~ (d) When a health maintenance organization or community integrated service network merges or consolidates with or is acquired by another health maintenance organization or community integrated service network, the surviving corporation or the new corporation shall be responsible for the annual surcharge originally imposed on each of the entities or corporations subject to the merger, consolidation, or acquisition, regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

~~(d)~~ (e) Effective July 1 of each year, the surviving corporation's or the new corporation's surcharge shall be based on the revenues earned in the second previous calendar year by all of the entities or corporations subject to the merger, consolidation, or acquisition regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N until the total

premium revenues of the surviving corporation include the total premium revenues of all the merged entities as reported to the commissioner of health.

~~(e)~~ (f) When a health maintenance organization or community integrated service network, which is subject to liability for the surcharge under this chapter, transfers, assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer of the health maintenance organization or community integrated service network.

~~(f)~~ (g) In the event a health maintenance organization or community integrated service network converts its licensure to a different type of entity subject to liability for the surcharge under this chapter, but survives in the same or substantially similar form, the surviving entity remains liable for the surcharge regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

~~(g)~~ (h) The surcharge assessed to a health maintenance organization or community integrated service network ends when the entity ceases providing services for premiums and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

EFFECTIVE DATE. This section is effective March 1, 2010.

Sec. 4. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Operating payment rates.** In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months of the rebased period beginning January 1, 2009. For the first ~~three~~ six months of the rebased period beginning January 1, 2011, rates shall not be rebased ~~at 74.25 percent of the full value of the rebasing percentage change.~~ From ~~April~~ July 1, 2011, to March 31, 2012, rates shall be rebased at 39.2 percent of the full value of the rebasing percentage change. Effective April 1, 2012, rates shall be rebased at full value. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services

covered by medical assistance and shall not include property cost information and costs recognized in outlier payments.

Sec. 5. Minnesota Statutes 2009 Supplement, 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 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~~ 2011, 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~~ 2011, 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~~ 2011, 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~~ 2011, to reflect this reduction.

(h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced one percent from the current statutory rates. 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 October 1, 2009, to reflect this reduction.

(i) In order to offset the ratable reductions provided for in this subdivision, the total payment rate for medical assistance fee-for-service admissions occurring on or after March 1, 2010, to June 30, 2011, made to Minnesota hospitals for inpatient services before third-party liability and spenddown, shall be increased by 14 percent from the current statutory rates if the hospital is located in Hennepin or Ramsey County and 18 percent from the current statutory rates for all other Minnesota hospitals. For purposes of this paragraph, medical assistance does not include general assistance medical care. This increase shall be paid from the account established in section 256D.032. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this paragraph. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments. The commissioner may ratably reduce payments under this paragraph in order to comply with section 256B.195, subdivision 3, paragraph (f).

EFFECTIVE DATE. This section is effective March 1, 2010.

Sec. 6. Minnesota Statutes 2008, section 256.969, subdivision 21, is amended to read:

Subd. 21. **Mental health or chemical dependency admissions; rates.** (a) Admissions under the general assistance medical care program occurring on or after July 1, 1990, and admissions under medical assistance, excluding general assistance medical care, occurring on or after July 1, 1990, and on or before September 30, 1992, that are classified to a diagnostic category of mental health or chemical dependency shall have rates established according to the methods of subdivision 14, except the per day rate shall be multiplied by a factor of 2, provided that the total of the per day rates shall not exceed the per admission rate. This methodology shall also apply when a hold or commitment is ordered by the court for the days that inpatient hospital services are medically necessary. Stays which are medically necessary for inpatient hospital services

and covered by medical assistance shall not be billable to any other governmental entity. Medical necessity shall be determined under criteria established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b).

(b) In order to ensure adequate access for the provision of mental health services and to encourage broader delivery of these services outside the nonstate governmental hospital setting, payment rates for medical assistance admissions occurring on or after March 1, 2010, to June 30, 2011, at a Minnesota private, not-for-profit hospital above the 75th percentile of all Minnesota private, nonprofit hospitals for diagnosis-related groups 424 to 432 and 521 to 523 admissions paid by medical assistance for admissions occurring in calendar year 2007, shall be increased for these diagnosis-related groups at a percentage calculated to cost not more than a total of \$50,000,000, including state and federal shares. This increase shall be paid from the account established in section 256D.032. For purposes of this paragraph, medical assistance does not include general assistance medical care. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this paragraph. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments. The commissioner may ratably reduce payments under this paragraph in order to comply with section 256B.195, subdivision 3, paragraph (f).

EFFECTIVE DATE. This section is effective March 1, 2010.

Sec. 7. Minnesota Statutes 2008, section 256.969, subdivision 26, is amended to read:

Subd. 26. **Greater Minnesota payment adjustment after June 30, 2001.** (a) For admissions occurring after June 30, 2001, the commissioner shall pay fee-for-service inpatient admissions for the diagnosis-related groups specified in paragraph (b) at hospitals located outside of the seven-county metropolitan area at the higher of:

(1) the hospital's current payment rate for the diagnostic category to which the diagnosis-related group belongs, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivision 23; or

(2) 90 percent of the average payment rate for that diagnostic category for hospitals located within the seven-county metropolitan area, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivisions 20 and 23.

(b) The payment increases provided in paragraph (a) apply to the following diagnosis-related groups, as they fall within the diagnostic categories:

(1) 370 cesarean section with complicating diagnosis;

- 10.1 (2) 371 cesarean section without complicating diagnosis;
- 10.2 (3) 372 vaginal delivery with complicating diagnosis;
- 10.3 (4) 373 vaginal delivery without complicating diagnosis;
- 10.4 (5) 386 extreme immaturity and respiratory distress syndrome, neonate;
- 10.5 (6) 388 full-term neonates with other problems;
- 10.6 (7) 390 prematurity without major problems;
- 10.7 (8) 391 normal newborn;
- 10.8 (9) 385 neonate, died or transferred to another acute care facility;
- 10.9 (10) 425 acute adjustment reaction and psychosocial dysfunction;
- 10.10 (11) 430 psychoses;
- 10.11 (12) 431 childhood mental disorders; and
- 10.12 (13) 164-167 appendectomy.

10.13 (c) For medical assistance admissions occurring on or after March 1, 2010, to June
10.14 30, 2011, the payment rate under paragraph (a), clause (2), shall be increased to 100
10.15 percent from 90 percent, after application of the rate increase in subdivision 3a, paragraph
10.16 (i). This increase shall be paid from the account established in section 256D.032. For
10.17 purposes of this paragraph, medical assistance does not include general assistance medical
10.18 care. The commissioner shall not adjust rates paid to a prepaid health plan under contract
10.19 with the commissioner to reflect payments provided in this paragraph. The commissioner
10.20 may utilize a settlement process to adjust rates in excess of the Medicare upper limits on
10.21 payments. The commissioner may ratably reduce payments under this paragraph in order
10.22 to comply with section 256B.195, subdivision 3, paragraph (f).

10.23 **EFFECTIVE DATE.** This section is effective March 1, 2010.

10.24 Sec. 8. Minnesota Statutes 2008, section 256.969, subdivision 27, is amended to read:

10.25 Subd. 27. **Quarterly payment adjustment.** (a) In addition to any other payment
10.26 under this section, the commissioner shall make the following payments effective July
10.27 1, 2007:

10.28 (1) for a hospital located in Minnesota and not eligible for payments under
10.29 subdivision 20, with a medical assistance inpatient utilization rate greater than 17.8
10.30 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal
10.31 to 13 percent of the total of the operating and property payment rates;

10.32 (2) for a hospital located in Minnesota in a specified urban area outside of the
10.33 seven-county metropolitan area and not eligible for payments under subdivision 20, with
10.34 a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total
10.35 patient days as of the base year in effect on July 1, 2005, a payment equal to ten percent

of the total of the operating and property payment rates. For purposes of this clause, the following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Alexandria, Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids, Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena;

(3) for a hospital located in Minnesota but not located in a specified urban area under clause (2), with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to four percent of the total of the operating and property payment rates. A hospital located in Woodbury and not in existence during the base year shall be reimbursed under this clause; and

(4) in addition to any payments under clauses (1) to (3), for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 17.9 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to eight percent of the total of the operating and property payment rates, and for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 59.6 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to nine percent of the total of the operating and property payment rates. After making any ratable adjustments required under paragraph (b), the commissioner shall proportionately reduce payments under clauses (2) and (3) by an amount needed to make payments under this clause.

(b) The state share of payments under paragraph (a) shall be equal to federal reimbursements to the commissioner to reimburse expenditures reported under section 256B.199. The commissioner shall ratably reduce or increase payments under this subdivision in order to ensure that these payments equal the amount of reimbursement received by the commissioner under section 256B.199, except that payments shall be ratably reduced by an amount equivalent to the state share of a four percent reduction in MinnesotaCare and medical assistance payments for inpatient hospital services. Effective July 1, 2009, the ratable reduction shall be equivalent to the state share of a three percent reduction in these payments. Effective for federal disproportionate share hospital funds earned on general assistance medical care payments for services rendered on or after March 1, 2010, to June 30, 2011, the amount of the three percent ratable reduction required under this paragraph shall be deposited in the account established in section 256D.032.

(c) The payments under paragraph (a) shall be paid quarterly based on each hospital's operating and property payments from the second previous quarter, beginning on July

15, 2007, or upon federal approval of federal reimbursements under section 256B.199, whichever occurs later.

(d) The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in paragraph (a).

(e) The commissioner shall maximize the use of available federal money for disproportionate share hospital payments and shall maximize payments to qualifying hospitals. In order to accomplish these purposes, the commissioner may, in consultation with the nonstate entities identified in section 256B.199, adjust, on a pro rata basis if feasible, the amounts reported by nonstate entities under section 256B.199 when application for reimbursement is made to the federal government, and otherwise adjust the provisions of this subdivision. The commissioner shall utilize a settlement process based on finalized data to maximize revenue under section 256B.199 and payments under this section.

(f) For purposes of this subdivision, medical assistance does not include general assistance medical care.

EFFECTIVE DATE. This section is effective for services rendered on or after March 1, 2010.

Sec. 9. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 30, is amended to read:

Subd. 30. **Payment rates for births.** (a) For admissions occurring on or after October 1, 2009, the total operating and property payment rate, excluding disproportionate population adjustment, for the following diagnosis-related groups, as they fall within the diagnostic categories: (1) 371 cesarean section without complicating diagnosis; (2) 372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without complicating diagnosis, shall be no greater than \$3,528.

(b) The rates described in this subdivision do not include newborn care.

(c) Payments to managed care and county-based purchasing plans under section 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in paragraph (a).

(d) Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery.

(e) In order to ensure adequate access for the provision of maternity services and to encourage broader delivery of these services outside the nonstate governmental hospital setting, and notwithstanding paragraph (a), payment rates for medical assistance admissions, excluding general assistance medical care admissions, occurring from March

1, 2010, to June 30, 2011, at a private, not-for-profit hospital above the 65th percentile of all Minnesota private, nonprofit hospitals for diagnosis-related groups 370 to 373, 388, 390, and 391 admissions paid by medical assistance for admissions provided in calendar year 2007, shall be increased for these diagnosis-related groups at a percentage calculated to cost not more than a total of \$42,000,000, including state and federal shares. This increase shall be paid from the account established in section 256D.032. For purposes of this paragraph, medical assistance does not include general assistance medical care. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this paragraph. The commissioner may utilize a settlement process to adjust rates in excess of the Medicare upper limits on payments. The commissioner may ratably reduce payments under this paragraph in order to comply with section 256B.195, subdivision 3, paragraph (f).

EFFECTIVE DATE. This section is effective March 1, 2010.

Sec. 10. Minnesota Statutes 2008, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

14.1 The commissioner must provide a 15-day notice period before implementing the prior
14.2 authorization.

14.3 (c) Except as provided in subdivision 13j, prior authorization shall not be required or
14.4 utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

14.5 (1) there is no generically equivalent drug available; and

14.6 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

14.7 (3) the drug is part of the recipient's current course of treatment.

14.8 This paragraph applies to any multistate preferred drug list or supplemental drug rebate
14.9 program established or administered by the commissioner. Prior authorization shall
14.10 automatically be granted for 60 days for brand name drugs prescribed for treatment of
14.11 mental illness within 60 days of when a generically equivalent drug becomes available,
14.12 provided that the brand name drug was part of the recipient's course of treatment at the
14.13 time the generically equivalent drug became available.

14.14 (d) Prior authorization shall not be required or utilized for any antihemophilic factor
14.15 drug prescribed for the treatment of hemophilia and blood disorders where there is no
14.16 generically equivalent drug available if the prior authorization is used in conjunction with
14.17 any supplemental drug rebate program or multistate preferred drug list established or
14.18 administered by the commissioner.

14.19 (e) The commissioner may require prior authorization for brand name drugs
14.20 whenever a generically equivalent product is available, even if the prescriber specifically
14.21 indicates "dispense as written-brand necessary" on the prescription as required by section
14.22 151.21, subdivision 2.

14.23 (f) Notwithstanding this subdivision, the commissioner may automatically require
14.24 prior authorization, for a period not to exceed 180 days, for any drug that is approved by
14.25 the United States Food and Drug Administration on or after July 1, 2005. The 180-day
14.26 period begins no later than the first day that a drug is available for shipment to pharmacies
14.27 within the state. The Formulary Committee shall recommend to the commissioner general
14.28 criteria to be used for the prior authorization of the drugs, but the committee is not
14.29 required to review each individual drug. In order to continue prior authorizations for a
14.30 drug after the 180-day period has expired, the commissioner must follow the provisions
14.31 of this subdivision.

14.32 **EFFECTIVE DATE.** This section is effective March 1, 2010.

14.33 Sec. 11. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
14.34 subdivision to read:

Subd. 13j. **Antipsychotic and attention deficit disorder and attention deficit hyperactivity disorder medications.** (a) The commissioner, in consultation with the Drug Utilization Review Board established in subdivision 13i and actively practicing pediatric mental health professionals, must:

(1) identify recommended pediatric dose ranges for atypical antipsychotic drugs and drugs used for attention deficit disorder or attention deficit hyperactivity disorder based on available medical, clinical, and safety data and research. The commissioner shall periodically review the list of medications and pediatric dose ranges and update the medications and doses listed as needed after consultation with the Drug Utilization Review Board;

(2) identify situations where a collaborative psychiatric consultation and prior authorization should be required before the initiation or continuation of drug therapy in pediatric patients including, but not limited to, high-dose regimens, off-label use of prescription medication, a patient's young age, and lack of coordination among multiple prescribing providers; and

(3) track prescriptive practices and the use of psychotropic medications in children with the goal of reducing the use of medication, where appropriate.

(b) Effective July 1, 2011, the commissioner shall require prior authorization and a collaborative psychiatric consultation before an atypical antipsychotic and attention deficit disorder and attention deficit hyperactivity disorder medication meeting the criteria identified in paragraph (a), clause (2), is eligible for payment. A collaborative psychiatric consultation must be completed before the identified medications are eligible for payment unless:

(1) the patient has already been stabilized on the medication regimen; or

(2) the prescriber indicates that the child is in crisis.

If clause (1) or (2) applies, the collaborative psychiatric consultation must be completed within 90 days for payment to continue.

(c) For purposes of this subdivision, a collaborative psychiatric consultation must meet the criteria described in section 245.4862, subdivision 5.

Sec. 12. Minnesota Statutes 2009 Supplement, 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 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.

(f) For federal fiscal years 2010 and 2011, payments under this subdivision shall be made at no less than the federal fiscal year 2009 level.

EFFECTIVE DATE. This section is effective March 1, 2010.

Sec. 13. Minnesota Statutes 2008, section 256B.69, is amended by adding a subdivision to read:

Subd. 5k. **Temporary rate modifications.** For services rendered effective May 1, 2010, to June 30, 2011, the total payment made to managed care plans under the medical assistance program and under MinnesotaCare for families with children shall be increased by 4.61 percent. This increase shall be paid from the account established in section 256D.032.

EFFECTIVE DATE. This section is effective March 1, 2010.

Sec. 14. Minnesota Statutes 2009 Supplement, 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 for applicants and recipients defined in paragraph (c), except as provided in paragraph (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.

(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.

(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 (f).

(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

19.1 beginning the date of application. Immediately following approval of general assistance
19.2 medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04,
19.3 subdivision 7, with covered services as provided in section 256L.03 for the rest of the
19.4 six-month general assistance medical care eligibility period, until their six-month renewal.

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

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

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

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

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

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

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

19.18 (6) are eligible under paragraph (k);

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

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

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

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

(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.

(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.

(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.

(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.

(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.

(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.

(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, subsection (a), paragraph (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.

(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.

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

(r) For the period beginning March 1, 2010, and ending July 1, 2011, the general assistance medical care program shall be administered according to section 256D.031, unless otherwise stated.

EFFECTIVE DATE. This section is effective March 1, 2010.

Sec. 15. Minnesota Statutes 2008, section 256D.03, subdivision 3a, is amended to read:

Subd. 3a. **Claims; assignment of benefits.** (a) Claims must be filed pursuant to section 256D.16. General assistance medical care applicants and recipients must apply or agree to apply third party health and accident benefits to the costs of medical care. They must cooperate with the state in establishing paternity and obtaining third party payments.

22.1 By accepting general assistance, a person assigns to the Department of Human Services
22.2 all rights to medical support or payments for medical expenses from another person or
22.3 entity on their own or their dependent's behalf and agrees to cooperate with the state in
22.4 establishing paternity and obtaining third party payments. The application shall contain
22.5 a statement explaining the assignment. Any rights or amounts assigned shall be applied
22.6 against the cost of medical care paid for under this chapter. An assignment is effective on
22.7 the date general assistance medical care eligibility takes effect.

22.8 (b) Effective for general assistance medical care services rendered on or after March
22.9 1, 2010, to June 30, 2011, any collections, payments, or recoveries under this subdivision
22.10 shall be deposited in the account established in section 256D.032.

22.11 **EFFECTIVE DATE.** This section is effective March 1, 2010.

22.12 Sec. 16. Minnesota Statutes 2008, section 256D.03, subdivision 3b, is amended to read:

22.13 Subd. 3b. **Cooperation.** (a) General assistance or general assistance medical care
22.14 applicants and recipients must cooperate with the state and local agency to identify
22.15 potentially liable third-party payors and assist the state in obtaining third-party payments.
22.16 Cooperation includes identifying any third party who may be liable for care and services
22.17 provided under this chapter to the applicant, recipient, or any other family member for
22.18 whom application is made and providing relevant information to assist the state in pursuing
22.19 a potentially liable third party. General assistance medical care applicants and recipients
22.20 must cooperate by providing information about any group health plan in which they may
22.21 be eligible to enroll. They must cooperate with the state and local agency in determining
22.22 if the plan is cost-effective. For purposes of this subdivision, coverage provided by the
22.23 Minnesota Comprehensive Health Association under chapter 62E shall not be considered
22.24 group health plan coverage or cost-effective by the state and local agency. If the plan is
22.25 determined cost-effective and the premium will be paid by the state or local agency or is
22.26 available at no cost to the person, they must enroll or remain enrolled in the group health
22.27 plan. Cost-effective insurance premiums approved for payment by the state agency and
22.28 paid by the local agency are eligible for reimbursement according to subdivision 6.

22.29 (b) Effective for all premiums due on or after June 30, 1997, general assistance
22.30 medical care does not cover premiums that a recipient is required to pay under a qualified
22.31 or Medicare supplement plan issued by the Minnesota Comprehensive Health Association.
22.32 General assistance medical care shall continue to cover premiums for recipients who are
22.33 covered under a plan issued by the Minnesota Comprehensive Health Association on June
22.34 30, 1997, for a period of six months following receipt of the notice of termination or
22.35 until December 31, 1997, whichever is later.

(c) Effective for general assistance medical care services rendered on or after March 1, 2010, to June 30, 2011, any collections, payments, or recoveries under this subdivision shall be deposited in the account established in section 256D.032.

EFFECTIVE DATE. This section is effective March 1, 2010.

Sec. 17. **[256D.031] GENERAL ASSISTANCE MEDICAL CARE.**

Subdivision 1. **Eligibility.** (a) Except as provided under subdivision 2, general assistance medical care may be paid for any individual 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, and who:

(1) is receiving assistance under section 256D.05, except for families with children who are eligible under the 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) is a resident of Minnesota and has gross countable income not in excess of 75 percent of 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.

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, except that 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.

(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.

Subd. 2. **Ineligible groups.** (a) General assistance medical care may not be paid for an applicant or a recipient who:

(1) is otherwise eligible for medical assistance but fails to verify their assets;

(2) is an adult in a family with children as defined in section 256L.01, subdivision 3a;

(3) is enrolled in private health coverage as defined in section 256B.02, subdivision 9;

(4) is in a correctional facility, including an individual in a county correctional or detention facility as an individual accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order;

(5) resides in the Minnesota sex offender program defined in chapter 246B;

24.1 (6) does not cooperate with the county agency to meet the requirements of medical
24.2 assistance; or

24.3 (7) does not cooperate with a county or state agency or the state medical review team
24.4 in determining a disability or for determining eligibility for Supplemental Security Income
24.5 or Social Security Disability Insurance by the Social Security Administration.

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

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

24.15 (d) General assistance medical care recipients who become eligible for medical
24.16 assistance shall be terminated from general assistance medical care and transferred to
24.17 medical assistance.

24.18 Subd. 3. **Transitional MinnesotaCare.** (a) Except as provided in paragraph (c),
24.19 effective March 1, 2010, all applicants and recipients who meet the eligibility requirements
24.20 in subdivision 1, paragraph (a), clause (2), and who are not described in subdivision 2
24.21 shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, immediately
24.22 following approval of general assistance medical care.

24.23 (b) If all other eligibility requirements of this subdivision are met, general assistance
24.24 medical care may be paid for individuals identified in paragraph (a) for a temporary
24.25 period beginning the date of application. Eligibility for general assistance medical care
24.26 shall continue until enrollment in MinnesotaCare is completed. Upon notification of
24.27 eligibility for MinnesotaCare, notice of termination for eligibility for general assistance
24.28 medical care shall be sent to the applicant or recipient. Once enrolled in MinnesotaCare,
24.29 the MinnesotaCare-covered services as described in section 256L.03 shall apply for the
24.30 remainder of the six-month general assistance medical care eligibility period until their
24.31 six-month renewal.

24.32 (c) This subdivision does not apply if the applicant or recipient:

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

24.36 (2) is homeless as defined by United States Code, title 42, section 11301, et seq.;

- 25.1 (3) is classified as an end-stage renal disease beneficiary in the Medicare program;
25.2 (4) receives treatment funded in section 254B.02; or
25.3 (5) fails to meet the requirements of section 256L.09, subdivision 2.

25.4 Applicants and recipients who meet any one of these criteria shall remain eligible for
25.5 general assistance medical care and shall not be required to enroll in MinnesotaCare.

25.6 (d) To be eligible for general assistance medical care following enrollment
25.7 in MinnesotaCare as required in paragraph (a), an individual must complete a new
25.8 application.

25.9 **Subd. 4. Eligibility and enrollment procedures.** (a) Eligibility for general
25.10 assistance medical care shall begin no earlier than the date of application. The date of
25.11 application shall be the date the applicant has provided a name, address, and Social
25.12 Security number, signed and dated, to the county agency or the Department of Human
25.13 Services. If the applicant is unable to provide a name, address, Social Security number,
25.14 and signature when health care is delivered due to a medical condition or disability, a
25.15 health care provider may act on an applicant's behalf to establish the date of an application
25.16 by providing the county agency or Department of Human Services with provider
25.17 identification and a temporary unique identifier for the applicant. The applicant must
25.18 complete the remainder of the application and provide necessary verification before
25.19 eligibility can be determined. The applicant must complete the application within the time
25.20 periods required under the medical assistance program as specified in Minnesota Rules,
25.21 parts 9505.0015, subpart 5; and 9505.0090, subpart 2. The county agency must assist the
25.22 applicant in obtaining verification if necessary.

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

25.27 (c) In determining the amount of assets of an individual eligible under subdivision 1,
25.28 paragraph (a), clause (2), there shall be included any asset or interest in an asset, including
25.29 an asset excluded under subdivision 1, paragraph (a), that was given away, sold, or
25.30 disposed of for less than fair market value within the 60 months preceding application for
25.31 general assistance medical care or during the period of eligibility. Any transfer described
25.32 in this paragraph shall be presumed to have been for the purpose of establishing eligibility
25.33 for general assistance medical care, unless the individual furnishes convincing evidence to
25.34 establish that the transaction was exclusively for another purpose. For purposes of this
25.35 paragraph, the value of the asset or interest shall be the fair market value at the time it
25.36 was given away, sold, or disposed of, less the amount of compensation received. For any

26.1 uncompensated transfer, the number of months of ineligibility, including partial months,
26.2 shall be calculated by dividing the uncompensated transfer amount by the average monthly
26.3 per person payment made by the medical assistance program to skilled nursing facilities
26.4 for the previous calendar year. The individual shall remain ineligible until this fixed period
26.5 has expired. The period of ineligibility may exceed 30 months, and a reapplication for
26.6 benefits after 30 months from the date of the transfer shall not result in eligibility unless
26.7 and until the period of ineligibility has expired. The period of ineligibility begins in the
26.8 month the transfer was reported to the county agency, or if the transfer was not reported,
26.9 the month in which the county agency discovered the transfer, whichever comes first. For
26.10 applicants, the period of ineligibility begins on the date of the first approved application.

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

26.16 Subd. 5. **General assistance medical care; services.** (a) General assistance
26.17 medical care covers:

26.18 (1) inpatient hospital services within the limitations described in subdivision 10;

26.19 (2) outpatient hospital services;

26.20 (3) services provided by Medicare-certified rehabilitation agencies;

26.21 (4) prescription drugs and other products recommended through the process
26.22 established in section 256B.0625, subdivision 13;

26.23 (5) equipment necessary to administer insulin and diagnostic supplies and equipment
26.24 for diabetics to monitor blood sugar level;

26.25 (6) eyeglasses and eye examinations provided by a physician or optometrist;

26.26 (7) hearing aids;

26.27 (8) prosthetic devices;

26.28 (9) laboratory and x-ray services;

26.29 (10) physicians' services;

26.30 (11) medical transportation except special transportation;

26.31 (12) chiropractic services as covered under the medical assistance program;

26.32 (13) podiatric services;

26.33 (14) dental services as covered under the medical assistance program;

26.34 (15) mental health services covered under chapter 256B;

26.35 (16) prescribed medications for persons who have been diagnosed as mentally ill as
26.36 necessary to prevent more restrictive institutionalization;

27.1 (17) medical supplies and equipment, and Medicare premiums, coinsurance, and
27.2 deductible payments;

27.3 (18) medical equipment not specifically listed in this paragraph when the use of
27.4 the equipment will prevent the need for costlier services that are reimbursable under
27.5 this subdivision;

27.6 (19) services performed by a certified pediatric nurse practitioner, a certified family
27.7 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological
27.8 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse
27.9 practitioner in independent practice, if (1) the service is otherwise covered under this
27.10 chapter as a physician service, (2) the service provided on an inpatient basis is not included
27.11 as part of the cost for inpatient services included in the operating payment rate, and (3) the
27.12 service is within the scope of practice of the nurse practitioner's license as a registered
27.13 nurse, as defined in section 148.171;

27.14 (20) services of a certified public health nurse or a registered nurse practicing in
27.15 a public health nursing clinic that is a department of, or that operates under the direct
27.16 authority of, a unit of government, if the service is within the scope of practice of the
27.17 public health nurse's license as a registered nurse, as defined in section 148.171;

27.18 (21) telemedicine consultations, to the extent they are covered under section
27.19 256B.0625, subdivision 3b;

27.20 (22) care coordination and patient education services provided by a community
27.21 health worker according to section 256B.0625, subdivision 49; and

27.22 (23) regardless of the number of employees that an enrolled health care provider
27.23 may have, sign language interpreter services when provided by an enrolled health care
27.24 provider during the course of providing a direct, person-to-person-covered health care
27.25 service to an enrolled recipient who has a hearing loss and uses interpreting services.

27.26 (b) Sex reassignment surgery is not covered under this section.

27.27 (c) Drug coverage is covered in accordance with section 256D.03, subdivision 4,
27.28 paragraph (d).

27.29 (d) The following co-payments shall apply for services provided:

27.30 (1) \$25 for nonemergency visits to a hospital-based emergency room; and

27.31 (2) \$3 per brand-name drug prescription, subject to a \$7 per month maximum for
27.32 prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when
27.33 used for the treatment of mental illness.

27.34 (e) Co-payments shall be limited to one per day per provider for nonemergency
27.35 visits to a hospital-based emergency room. Recipients of general assistance medical care
27.36 are responsible for all co-payments in this subdivision. Reimbursement for prescription

drugs shall be reduced by the amount of the co-payment until the recipient has reached the \$7 per month maximum for prescription drug co-payments. The provider shall collect the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

(f) Chemical dependency services that are reimbursed under chapter 254B shall not be reimbursed under general assistance medical care.

(g) Inpatient hospital services that are provided in community behavioral health hospitals operated by state-operated services shall not be reimbursed under general assistance medical care.

Subd. 6. Coordinated care delivery option. (a) A county or group of counties may elect to provide health care and supportive services to individuals who are eligible for general assistance medical care under this section and who reside within the county or counties through a coordinated care delivery option. The health care services provided by the county must include the services described in subdivision 5 with the exception of outpatient prescription drug coverage but including drugs administered in an outpatient setting. Support services may include, but are not limited to, social services, outreach, health care navigation, housing, and transportation. Counties that elect to provide health care services through this option must ensure that the requirements of this subdivision are met. Upon electing to provide services through this option, the county accepts the financial risk of the delivery of the health care services described in this subdivision to general assistance medical care recipients residing in the county for the period beginning July 1, 2010, and ending July 1, 2011, for the fixed payments described in subdivision 10.

(b) A county that elects to provide services through this option must provide to the commissioner the following:

(1) the names of the county or counties that are electing to provide services through the county care delivery option; and

(2) the geographic area to be served.

(c) The county may contract with a managed care plan, an integrated delivery system, a physician-hospital organization, or an academic health center to administer the delivery of services through this option. Any county providing general assistance medical care services through a county-based purchasing plan in accordance with section 256B.692 may continue to provide services through the county-based purchasing plan. Payments to the county-based purchasing plan for the period beginning July 1, 2010, and ending July 1, 2011, shall be paid according to subdivision 10.

(d) A county must demonstrate the ability to:

(1) provide the covered services required under this subdivision to recipients residing within the county;

(2) provide a system for advocacy, consumer protection, and complaints and appeals that is independent of care providers or other risk bearers and complies with section 256B.69;

(3) establish a process to ensure and improve the quality of care provided; and

(4) coordinate the delivery of health care services with existing homeless prevention, supportive housing, and rent subsidy programs and funding administered by the Minnesota Housing Finance Agency under chapter 462A.

(e) The commissioner may require the county to provide the commissioner with data necessary for assessing quality of care, cost, and utilization of services.

(f) A county that elects to provide services through this option shall be considered to be a prepaid health plan for purposes of section 256.045.

(g) The state shall not be liable for the payment of any cost or obligation incurred by the county or a participating provider.

Subd. 7. **Health care home designation.** The commissioner or a county may require a recipient to designate a primary care provider or a primary care clinic that is certified as a health care home under section 256B.0751.

Subd. 8. **Payments; fee-for-service rate for the period between March 1, 2010, and July 1, 2010.** (a) Effective for services provided on or after March 1, 2010, and before July 1, 2010, the payment rates for all covered services provided to general assistance medical care recipients, with the exception of outpatient prescription drug coverage, shall be 50 percent of the general assistance medical care payment rate in effect on February 28, 2010.

(b) Outpatient prescription drug coverage provided on or after March 1, 2010, and before July 1, 2010, shall be paid on a fee-for-service basis in accordance with section 256B.0625, subdivision 13e.

Subd. 9. **Payments; fee-for-service rates for the period between July 1, 2010, and July 1, 2011.** (a) Effective for services provided on or after July 1, 2010, and before July 1, 2011, to general assistance medical care recipients residing in counties that are not served through the coordinated care delivery option, payments shall be made by the commissioner to providers at rates described in this subdivision.

(b) For inpatient hospital admissions provided on or after July 1, 2010, and before July 1, 2011, the payment rate shall be:

(1) 70 percent of the general assistance medical care rate in effect on February 28, 2010, if the inpatient hospital services were provided in a hospital where the

30.1 fee-for-service inpatient and outpatient hospital general assistance medical care payments
30.2 to the hospital for admissions provided in calendar year 2007 totaled \$1,000,000 or more
30.3 or the hospital's fee-for-service inpatient and outpatient hospital general assistance medical
30.4 care payments received for calendar year 2007 admissions was one percent or more of the
30.5 hospital's net patient revenue received for services provided in calendar year 2007; or
30.6 (2) 40 percent of the general assistance medical care rate in effect on February 28,
30.7 2010, if the inpatient hospital services were provided by a hospital that does not meet the
30.8 criteria described in clause (1).

30.9 (c) Effective for services other than inpatient hospital services and outpatient
30.10 prescription drug coverage provided on or after July 1, 2010, and before July 1, 2011,
30.11 the payment rate shall begin at 50 percent of the general assistance medical care rate
30.12 in effect on February 28, 2010.

30.13 (d) Outpatient prescription drug coverage provided on or after July 1, 2010, and
30.14 before July 1, 2011, shall be paid on a fee-for-service basis in accordance with section
30.15 256B.0625, subdivision 13e.

30.16 (e) The commissioner may adjust the rates paid under paragraphs (b) and (c) on a
30.17 quarterly basis to ensure that the total aggregate amount paid out for services provided
30.18 on a fee-for-service basis beginning March 1, 2010, and ending June 30, 2011, does not
30.19 exceed the appropriation from the general assistance medical care account established in
30.20 section 256D.032 for the general assistance medical care program.

30.21 Subd. 10. **Payments; rate setting for the coordinated care delivery option.** (a)
30.22 Effective for general assistance medical care services, with the exception of outpatient
30.23 prescription drug coverage, provided on or after July 1, 2010, and before July 1, 2011,
30.24 to recipients residing in counties that have elected to provide services through the
30.25 coordinated delivery care option, the commissioner shall establish quarterly prospective
30.26 fixed payments to the county. The payments must not exceed 60 percent of the county's
30.27 general assistance medical care county allocation amount as determined in paragraph (b).
30.28 These payments must not be used by the county to pay MinnesotaCare premiums for
30.29 general assistance medical care recipients or MinnesotaCare enrollees.

30.30 (b) For each county that elects to provide services in accordance with subdivision
30.31 7, the commissioner shall determine a general assistance medical care county allocation
30.32 amount that equals the total general assistance medical care payments made for recipients
30.33 residing within the county in fiscal year 2009 for all covered general assistance medical
30.34 care services with the exception of outpatient prescription drug coverage.

31.1 (c) Outpatient prescription drug coverage provided on or after July 1, 2010,
31.2 and before July 1, 2011, shall be paid on a fee-for-service basis according to section
31.3 256B.0625, subdivision 13e.

31.4 Subd. 11. **Unallotment.** Appropriations for this program are not subject to section
31.5 16A.152, subdivision 4.

31.6 **EFFECTIVE DATE.** This section is effective for services rendered on or after
31.7 March 1, 2010, and before July 1, 2011.

31.8 Sec. 18. **[256D.032] GENERAL ASSISTANCE MEDICAL CARE ACCOUNT.**

31.9 The general assistance medical care account is created in the special revenue fund.
31.10 Money deposited into the account is subject to appropriation by the legislature.

31.11 **EFFECTIVE DATE.** This section is effective March 1, 2010.

31.12 Sec. 19. Minnesota Statutes 2008, section 256D.06, subdivision 7, is amended to read:

31.13 Subd. 7. **SSI conversions and back claims.** (a) The commissioner of human
31.14 services shall contract with agencies or organizations capable of ensuring that clients who
31.15 are presently receiving assistance under sections 256D.01 to 256D.21, and who may be
31.16 eligible for benefits under the federal Supplemental Security Income program, apply and,
31.17 when eligible, are converted to the federal income assistance program and made eligible
31.18 for health care benefits under the medical assistance program. The commissioner shall
31.19 ensure that money owing to the state under interim assistance agreements is collected.

31.20 (b) The commissioner shall also directly or through contract implement procedures
31.21 for collecting federal Medicare and medical assistance funds for which clients converted
31.22 to SSI are retroactively eligible.

31.23 (c) The commissioner shall contract with agencies to ensure implementation of
31.24 this section. County contracts with providers for residential services shall include the
31.25 requirement that providers screen residents who may be eligible for federal benefits and
31.26 provide that information to the local agency. The commissioner shall modify the MAXIS
31.27 computer system to provide information on clients who have been on general assistance
31.28 for two years or longer. The list of clients shall be provided to local services for screening
31.29 under this section.

31.30 (d) Effective for general assistance medical care services rendered on or after March
31.31 1, 2010, to June 30, 2011, any collections, payments, or recoveries under this subdivision
31.32 shall be deposited in the account established in section 256D.032.

31.33 **EFFECTIVE DATE.** This section is effective March 1, 2010.

32.1 Sec. 20. Minnesota Statutes 2008, section 256L.05, subdivision 1b, is amended to read:

32.2 Subd. 1b. **MinnesotaCare enrollment by county agencies.** Beginning September
32.3 1, 2006, county agencies shall enroll single adults and households with no children
32.4 formerly enrolled in general assistance medical care in MinnesotaCare according to
32.5 section 256D.03, subdivision 3, or 256D.031. County agencies shall perform all duties
32.6 necessary to administer the MinnesotaCare program ongoing for these enrollees, including
32.7 the redetermination of MinnesotaCare eligibility at renewal.

32.8 **EFFECTIVE DATE.** This section is effective March 1, 2010.

32.9 Sec. 21. Minnesota Statutes 2008, section 256L.05, subdivision 3, is amended to read:

32.10 Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the
32.11 first day of the month following the month in which eligibility is approved and the first
32.12 premium payment has been received. As provided in section 256B.057, coverage for
32.13 newborns is automatic from the date of birth and must be coordinated with other health
32.14 coverage. The effective date of coverage for eligible newly adoptive children added to a
32.15 family receiving covered health services is the month of placement. The effective date
32.16 of coverage for other new members added to the family is the first day of the month
32.17 following the month in which the change is reported. All eligibility criteria must be met
32.18 by the family at the time the new family member is added. The income of the new family
32.19 member is included with the family's gross income and the adjusted premium begins in
32.20 the month the new family member is added.

32.21 (b) The initial premium must be received by the last working day of the month for
32.22 coverage to begin the first day of the following month.

32.23 (c) Benefits are not available until the day following discharge if an enrollee is
32.24 hospitalized on the first day of coverage.

32.25 (d) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to
32.26 256L.18 are secondary to a plan of insurance or benefit program under which an eligible
32.27 person may have coverage and the commissioner shall use cost avoidance techniques to
32.28 ensure coordination of any other health coverage for eligible persons. The commissioner
32.29 shall identify eligible persons who may have coverage or benefits under other plans of
32.30 insurance or who become eligible for medical assistance.

32.31 (e) The effective date of coverage for single adults and households with no children
32.32 formerly enrolled in general assistance medical care and enrolled in MinnesotaCare
32.33 according to section 256D.03, subdivision 3, or 256D.031, is the first day of the month
32.34 following the last day of general assistance medical care coverage.

33.1 **EFFECTIVE DATE.** This section is effective March 1, 2010.

33.2 Sec. 22. Minnesota Statutes 2008, section 256L.05, subdivision 3a, is amended to read:

33.3 Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007, an enrollee's eligibility
33.4 must be renewed every 12 months. The 12-month period begins in the month after the
33.5 month the application is approved.

33.6 (b) Each new period of eligibility must take into account any changes in
33.7 circumstances that impact eligibility and premium amount. An enrollee must provide all
33.8 the information needed to redetermine eligibility by the first day of the month that ends
33.9 the eligibility period. If there is no change in circumstances, the enrollee may renew
33.10 eligibility at designated locations that include community clinics and health care providers'
33.11 offices. The designated sites shall forward the renewal forms to the commissioner. The
33.12 commissioner may establish criteria and timelines for sites to forward applications to the
33.13 commissioner or county agencies. The premium for the new period of eligibility must be
33.14 received as provided in section 256L.06 in order for eligibility to continue.

33.15 (c) For single adults and households with no children formerly enrolled in general
33.16 assistance medical care and enrolled in MinnesotaCare according to section 256D.03,
33.17 subdivision 3, or 256D.031, the first period of eligibility begins the month the enrollee
33.18 submitted the application or renewal for general assistance medical care.

33.19 (d) An enrollee who fails to submit renewal forms and related documentation
33.20 necessary for verification of continued eligibility in a timely manner shall remain eligible
33.21 for one additional month beyond the end of the current eligibility period before being
33.22 disenrolled. The enrollee remains responsible for MinnesotaCare premiums for the
33.23 additional month.

33.24 Sec. 23. Minnesota Statutes 2008, section 256L.07, subdivision 6, is amended to read:

33.25 Subd. 6. **Exception for certain adults.** Single adults and households with
33.26 no children formerly enrolled in general assistance medical care and enrolled in
33.27 MinnesotaCare according to section 256D.03, subdivision 3, or 256D.031, are eligible
33.28 without meeting the requirements of this section until renewal.

33.29 **EFFECTIVE DATE.** This section is effective March 1, 2010.

33.30 Sec. 24. Minnesota Statutes 2008, section 256L.15, subdivision 4, is amended to read:

33.31 Subd. 4. **Exception for transitioned adults.** County agencies shall pay premiums
33.32 for single adults and households with no children formerly enrolled in general assistance
33.33 medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3,

34.1 or 256D.031, until six-month renewal. The county agency has the option of continuing to
34.2 pay premiums for these enrollees.

34.3 **EFFECTIVE DATE.** This section is effective March 1, 2010.

34.4 Sec. 25. Minnesota Statutes 2008, section 256L.17, subdivision 7, is amended to read:

34.5 Subd. 7. **Exception for certain adults.** Single adults and households with
34.6 no children formerly enrolled in general assistance medical care and enrolled in
34.7 MinnesotaCare according to section 256D.03, subdivision 3, or 256D.031, are exempt
34.8 from the requirements of this section until renewal.

34.9 **EFFECTIVE DATE.** This section is effective March 1, 2010.

34.10 Sec. 26. **DRUG REBATE PROGRAM.**

34.11 The commissioner of human services shall continue to administer a drug rebate
34.12 program for drugs purchased for persons eligible for the general assistance medical care
34.13 program in accordance with Minnesota Statutes, sections 256.01, subdivision 2, paragraph
34.14 (cc), and 256D.03. The rebate revenues collected under the drug rebate program for
34.15 persons eligible for the general assistance medical care program shall be deposited in the
34.16 general assistance medical care account in the special revenue fund established under
34.17 Minnesota Statutes, section 256D.032.

34.18 **EFFECTIVE DATE.** This section is effective March 1, 2010, and expires June
34.19 30, 2011.

34.20 Sec. 27. **PROVIDER PARTICIPATION.**

34.21 For purposes of Minnesota Statutes, section 256B.0644, the reference to the general
34.22 assistance medical care program shall include the temporary general assistance medical
34.23 care program established under Minnesota Statutes, section 256D.031. In meeting the
34.24 requirements of Minnesota Statutes, section 256B.0644, a provider must accept new
34.25 patients regardless of the Minnesota health care program the patient is enrolled in and may
34.26 not refuse to accept patients enrolled in one Minnesota health care program and continue
34.27 to accept patients enrolled in other Minnesota health care programs.

34.28 **EFFECTIVE DATE.** This section is effective March 1, 2010.

34.29 Sec. 28. **TEMPORARY SUSPENSION.**

(a) For the period beginning March 1, 2010, to June 30, 2011, the commissioner of human services shall not implement or administer Minnesota Statutes 2008, section 256D.03, subdivisions 6 and 9; Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4; or Minnesota Statutes 2008, section 256B.692; and Minnesota Statutes 2009 Supplement, section 256B.69, as they apply to the general assistance medical care program unless specifically continued in Minnesota Statutes, section 256D.031.

(b) Notwithstanding paragraph (a), outpatient prescription drug coverage shall continue to be provided under Minnesota Statutes, section 256D.03.

EFFECTIVE DATE. This section is effective March 1, 2010, and expires July 1, 2011.

Sec. 29. **MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION
ASSESSMENT MODIFICATION; TRANSFER.**

Subdivision 1. Minnesota Comprehensive Health Association assessment modification. For the purpose of the annual assessment allocation required in Minnesota Statutes, section 62E.11, the Minnesota Comprehensive Health Association shall credit \$..... to HealthPartners' assessment for calendar year 2010 and \$..... to HealthPartners' assessment for calendar year 2011, upon receipt by the association of the transfers specified in subdivision 2.

Subd. 2. Transfer. \$..... shall be transferred in fiscal year 2011 and \$..... in fiscal year 2012 from the general assistance medical care account established in Minnesota Statutes, section 256D.032, to the commissioner of commerce for disbursement upon receipt to the Minnesota Comprehensive Health Association, to compensate for the loss in the association's assessments created by the credits specified in subdivision 1.

Sec. 30. **APPROPRIATION TRANSFERS.**

(a) Of the general fund appropriation to the commissioner of human services for health care management in Laws 2009, chapter 79, article 13, section 3, subdivision 7, as amended by Laws 2009, chapter 173, article 2, section 1, \$3,300,000 for health care administration and \$4,100,000 for health care operations shall be transferred on March 1, 2010, to the fund established in Minnesota Statutes, section 256D.032. These amounts are appropriated to the commissioner for the administration and operation of the general assistance medical care program under Minnesota Statutes, section 256D.031. For purposes of consistent cost allocation and accounting, the commissioner may transfer the amounts appropriated for program administration and operation to the general fund.

(b) Of the general fund appropriation to the commissioner of human services for general assistance medical care grants in fiscal year 2010 in Laws 2009, chapter 79, article 13, section 3, subdivision 6, paragraph (d), as amended by Laws 2009, chapter 173, article 2, section 1, \$34,000,000 shall be transferred on March 1, 2010, to the fund established in Minnesota Statutes, section 256D.032, and any unexpended amount not used for general assistance medical care expenditures incurred prior to March 1, 2010, does not cancel and shall be transferred to the fund established in Minnesota Statutes, section 256D.032, by January 1, 2011.

EFFECTIVE DATE. This section is effective March 1, 2010.

Sec. 31. **APPROPRIATION REDUCTION; TRANSFER.**

(a) The general fund appropriation to the commissioner of human services for children and community services grants in Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 4, is reduced by \$17,000,000 in fiscal year 2011. For the biennium beginning July 1, 2011, the base level funding for these grants shall be \$67,542,000.

(b) The general fund appropriation to the commissioner of human services for the adult mental health integrated fund in Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, is reduced by \$12,000,000 in fiscal year 2011. For the biennium beginning July 1, 2011, the base level funding for these grants shall be \$77,739,000.

(c) \$29,000,000 shall be transferred in fiscal year 2011 from the general fund to the general assistance medical care account established in section 256D.032.

Sec. 32. **APPROPRIATIONS.**

The following appropriations are from the account established in Minnesota Statutes, section 256D.032, to the commissioner of human services for the time periods and purposes indicated:

(1) \$..... for the period from March 1, 2010, to June 30, 2010, and \$..... for fiscal year 2011 for the hospital rate increases under Minnesota Statutes, section 256.969. The commissioner may transfer these appropriations to the medical assistance account in the general fund and pay the rate increases from the medical assistance account;

(2) \$..... for the period from May 1, 2010, to June 30, 2010, and \$..... for fiscal year 2011 for the managed care plan rate increase in Minnesota Statutes, section 256B.69, subdivision 5k. The commissioner may transfer these appropriations to the medical

- 37.1 assistance account in the general fund and pay the rate increases from the medical
37.2 assistance account; and
37.3 (3) \$..... for the period from March 1, 2010, to June 30, 2010, and \$..... for fiscal
37.4 year 2011 for the general assistance medical care program established in Minnesota
37.5 Statutes, section 256D.031.
- 37.6 **EFFECTIVE DATE.** This section is effective March 1, 2010.