

A bill for an act

relating to human services; making changes to health care program provisions; making technical and policy changes; clarifying obsolete language; making federal conformity changes; clarifying eligibility requirements; modifying pharmaceutical provisions; clarifying certain covered services; eliminating the elderly waiver payment; providing a right to appeal and appeal processes; imposing provider requirements; requiring a report on nonemergency medical transportation; requiring reporting of managed care and county-based purchasing data; providing civil penalties; amending Minnesota Statutes 2010, sections 13.461, subdivision 24a; 256B.02, by adding a subdivision; 256B.03, by adding subdivisions; 256B.04, by adding a subdivision; 256B.056, subdivisions 1c, 3, 3c; 256B.057, subdivision 9; 256B.0625, subdivisions 13, 13d, 13e, 17a, 22, 31; 256B.064, subdivision 2; 256B.0641, subdivision 1; 256B.0659, subdivision 30; 256B.199; 256B.27, subdivision 3; 256B.69, subdivisions 5, 28, by adding a subdivision; 256L.04, subdivision 7b; 256L.05, subdivision 3; 256L.11, subdivision 6; 256L.15, subdivision 1; Laws 2010, First Special Session chapter 1, article 16, sections 8; 9; 10; repealing Minnesota Statutes 2010, sections 256.01, subdivision 18b; 256B.69, subdivision 9b.

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

ARTICLE 1

REHABILITATION TECHNICAL

Section 1. Laws 2010, First Special Session chapter 1, article 16, section 8, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective July 1, 2010, for services provided through fee-for-service, ~~and January 1, 2011, for services provided through managed care.~~

EFFECTIVE DATE. This section is effective retroactively from January 1, 2011.

Sec. 2. Laws 2010, First Special Session chapter 1, article 16, section 9, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective July 1, 2010, for services provided through fee-for-service, ~~and January 1, 2011, for services provided through managed care.~~

EFFECTIVE DATE. This section is effective retroactively from January 1, 2011.

Sec. 3. Laws 2010, First Special Session chapter 1, article 16, section 10, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective July 1, 2010, for services provided through fee-for-service, ~~and January 1, 2011, for services provided through managed care.~~

EFFECTIVE DATE. This section is effective retroactively from January 1, 2011.

ARTICLE 2

PERSONAL CARE ASSISTANCE SERVICES

Section 1. Minnesota Statutes 2010, section 256B.0659, subdivision 30, is amended to read:

Subd. 30. **Notice of service changes to recipients.** The commissioner must provide:

(1) by October 31, 2009, information to recipients likely to be affected that (i) describes the changes to the personal care assistance program that may result in the loss of access to personal care assistance services, and (ii) includes resources to obtain further information;

(2) notice of changes in medical assistance personal care assistance services to each affected recipient at least 30 days before the effective date of the change.

The notice shall include how to get further information on the changes, how to get help to obtain other services, a list of community resources, and appeal rights. Notwithstanding section 256.045, a recipient may request continued services pending appeal within ~~the time period allowed to request an appeal~~ 30 days after the notice of change in personal care assistance services, or before the effective date of action, whichever is later. A managed care enrollee may request continuation of services pending an appeal to the state within ten days after the written resolution of a managed care organization appeal, or before the effective date of action, whichever is later; and

(3) a service agreement authorizing personal care assistance hours of service at the previously authorized level, throughout the appeal process period, when a recipient requests services pending an appeal.

ARTICLE 3

FEDERAL POVERTY GUIDELINES

Section 1. Minnesota Statutes 2010, section 256B.056, subdivision 1c, is amended to read:

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

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

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

(b) For families with children whose eligibility is determined using the standard specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable earned income shall be disregarded for up to four months and the following deductions shall be applied to each individual's income counted toward eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: dependent care and child support paid under court order.

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

(d) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services except that the income standards shall not go below ~~those~~ the income standards in effect on July 1, 2009 of the preceding year.

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

Sec. 2. Minnesota Statutes 2010, section 256L.04, subdivision 7b, is amended to read:

Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income limits 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 except that the income standards shall not go below ~~those~~ the income standards in effect on the preceding July 1, ~~2009~~.

ARTICLE 4

CLARIFICATION OF AMERICAN INDIAN LANGUAGE IN ARRA

Section 1. Minnesota Statutes 2010, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for medical assistance, a person must not individually own more than \$3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than \$6,000 in assets, plus \$200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

- (1) household goods and personal effects are not considered;
- (2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;
- (3) motor vehicles are excluded to the same extent excluded by the supplemental security income program;
- (4) assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses; ~~and~~

(5) effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (c); and

(6) effective July 1, 2009, certain assets owned by American Indians are excluded, as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is a person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

Sec. 2. Minnesota Statutes 2010, section 256B.056, subdivision 3c, is amended to read:

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

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

(2) capital and operating assets of a trade or business up to \$200,000 are not considered, except that a bank account that contains personal income or assets, or is used to pay personal expenses, is not considered a capital or operating asset of a trade or business;

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

(4) assets designated as burial expenses are excluded to the same extent they are excluded by the Supplemental Security Income program;

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

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

(7) assets owned by children are not considered; and

(8) effective July 1, 2009, certain assets owned by American Indians are excluded, as required by section 5006 of the American Recovery and Reinvestment Act of 2009,

Public Law 111-5. For purposes of this clause, an American Indian is a person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

The assets specified in clause (2) must be disclosed to the local agency at the time of application and at the time of an eligibility redetermination, and must be verified upon request of the local agency.

Sec. 3. Minnesota Statutes 2010, section 256B.057, subdivision 9, is amended to read:

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

(1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;

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

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

(4) pays a premium and other obligations under paragraph (e).

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

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

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

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

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

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

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

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

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

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

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

(ii) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this paragraph, an American Indian is a person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

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

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

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

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

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

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month

after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

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

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

(j) The commissioner shall notify enrollees annually beginning at least 24 months before the person's 65th birthday of the medical assistance eligibility rules affecting income, assets, and treatment of a spouse's income and assets that will be applied upon reaching age 65.

Sec. 4. Minnesota Statutes 2010, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and either the first premium payment or documentation of American Indian status according to section 256L.15, subdivision 1, paragraph (d), has been received. As provided in section 256B.057, coverage for newborns is automatic from the date of birth and must be coordinated with other health coverage. The effective date of coverage for eligible newly adoptive children added to a family receiving covered health services is the month of placement. The effective date of coverage for other new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's gross income and the adjusted premium begins in the month the new family member is added.

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

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

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

Sec. 5. Minnesota Statutes 2010, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **Premium determination.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

(c) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption applies for 12 months. This paragraph expires June 30, 2010. If the expiration of this provision is in violation of section 5001 of Public Law 111-5, this provision will expire on the date when it is no longer subject to section 5001 of Public Law 111-5. The commissioner of human services shall notify the revisor of statutes of that date.

(d) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their families must have their premiums waived by the commissioner in accordance with section 5006 of Public Law 111-5. An individual must document status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the exception from premium requirements.

Sec. 6. **REPEALER.**

Minnesota Statutes 2010, section 256.01, subdivision 18b, is repealed.

ARTICLE 5

ACTIVE PHARMACEUTICAL INGREDIENTS

Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 13, is amended to read:

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

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

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

(1) a commercially available product is not a therapeutic option for the patient;

(2) a commercially available product does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) a commercially available product cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

~~(c)~~ (d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the

requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

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

Sec. 2. Minnesota Statutes 2010, section 256B.0625, subdivision 13d, is amended to read:

Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the Formulary Committee shall review and comment on the formulary contents.

(b) The formulary shall not include:

(1) drugs, active pharmaceutical ingredients, or products for which there is no federal funding;

(2) over-the-counter drugs, except as provided in subdivision 13;

(3) drugs or active pharmaceutical ingredients used for weight loss, except that medically necessary lipase inhibitors may be covered for a recipient with type II diabetes;

(4) drugs or active pharmaceutical ingredients when used for the treatment of impotence or erectile dysfunction;

(5) drugs or active pharmaceutical ingredients for which medical value has not been established; and

(6) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act.

(c) If a single-source drug used by at least two percent of the fee-for-service medical assistance recipients is removed from the formulary due to the failure of the manufacturer to sign a rebate agreement with the Department of Health and Human Services, the commissioner shall notify prescribing practitioners within 30 days of receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was not signed.

ARTICLE 6

MINIMUM QUANTITY OF OVER-THE-COUNTER DRUGS

Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 13, is amended to read:

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

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

(c) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

Over-the-counter medications must be dispensed in a quantity that is the lower of:

(1) the number of dosage units contained in the manufacturer's original package; and

(2) the number of dosage units required to complete the patient's course of therapy.

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

Sec. 2. Minnesota Statutes 2010, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be \$3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be \$8 per bag, \$14 per bag for cancer chemotherapy products, and \$30 per bag for total parenteral nutritional products dispensed in one liter quantities, or \$44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. Effective July 1, 2009, the actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus 15 percent. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under

14.1 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug.
14.2 The National Drug Code (NDC) from the drug container used to fill the blister card must
14.3 be identified on the claim to the department. The unit dose blister card containing the
14.4 drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700,
14.5 that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider
14.6 will be required to credit the department for the actual acquisition cost of all unused
14.7 drugs that are eligible for reuse. ~~Over-the-counter medications must be dispensed in the~~
14.8 ~~manufacturer's unopened package.~~ The commissioner may permit the drug clozapine to be
14.9 dispensed in a quantity that is less than a 30-day supply.

14.10 (c) Whenever a maximum allowable cost has been set for a multisource drug,
14.11 payment shall be on the basis of the maximum allowable cost established by the
14.12 commissioner unless prior authorization for the brand name product has been granted
14.13 according to the criteria established by the Drug Formulary Committee as required by
14.14 subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on
14.15 the prescription in a manner consistent with section 151.21, subdivision 2.

14.16 (d) The basis for determining the amount of payment for drugs administered in an
14.17 outpatient setting shall be the lower of the usual and customary cost submitted by the
14.18 provider or the amount established for Medicare by the United States Department of
14.19 Health and Human Services pursuant to title XVIII, section 1847a of the federal Social
14.20 Security Act.

14.21 (e) The commissioner may negotiate lower reimbursement rates for specialty
14.22 pharmacy products than the rates specified in paragraph (a). The commissioner may
14.23 require individuals enrolled in the health care programs administered by the department
14.24 to obtain specialty pharmacy products from providers with whom the commissioner has
14.25 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
14.26 used by a small number of recipients or recipients with complex and chronic diseases
14.27 that require expensive and challenging drug regimens. Examples of these conditions
14.28 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
14.29 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
14.30 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
14.31 biotechnology drugs, high-cost therapies, and therapies that require complex care. The
14.32 commissioner shall consult with the formulary committee to develop a list of specialty
14.33 pharmacy products subject to this paragraph. In consulting with the formulary committee
14.34 in developing this list, the commissioner shall take into consideration the population
14.35 served by specialty pharmacy products, the current delivery system and standard of care in

15.1 the state, and access to care issues. The commissioner shall have the discretion to adjust
15.2 the reimbursement rate to prevent access to care issues.

15.3 (f) Home infusion therapy services provided by home infusion therapy pharmacies
15.4 must be paid at rates according to subdivision 8d.

15.5 **ARTICLE 7**

15.6 **AMBULANCE REIMBURSEMENT**

15.7 Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 17a, is amended to
15.8 read:

15.9 Subd. 17a. **Payment for ambulance services.** Medical assistance covers ambulance
15.10 services. Providers shall bill ambulance services ~~according to Medicare criteria.~~ using
15.11 diagnosis codes indicating the condition that was treated by the ambulance crew. The
15.12 list of advanced life support and basic life support covered diagnosis codes must be
15.13 updated monthly by the commissioner and made available on the department's Web
15.14 site. Nonemergency ambulance services shall not be paid as emergencies. Effective for
15.15 services rendered on or after July 1, 2001, medical assistance payments for ambulance
15.16 services shall be paid at the Medicare reimbursement rate or at the medical assistance
15.17 payment rate in effect on July 1, 2000, whichever is greater.

15.18 **ARTICLE 8**

15.19 **HOSPICE AGE**

15.20 Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 22, is amended to
15.21 read:

15.22 Subd. 22. **Hospice care.** Medical assistance covers hospice care services under
15.23 ~~Public Law 99-272, section 9505~~ United States Code, title 42, section 1396d(o), to the
15.24 extent authorized by rule, except that a recipient age ~~21~~ 20 or under who elects to receive
15.25 hospice services does not waive coverage for services that are related to the treatment of
15.26 the condition for which a diagnosis of terminal illness has been made.

15.27 **ARTICLE 9**

15.28 **DURABLE MEDICAL EQUIPMENT DEFINITION AND**
15.29 **ACCREDITATION FOR SUPPLIERS**

15.30 Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 31, is amended to
15.31 read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient. The commissioner may set reimbursement rates for specified categories of medical supplies at levels below the Medicare payment rate.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

ARTICLE 10

ELIMINATE ELDERLY WAIVER PAYMENT

Section 1. Minnesota Statutes 2010, section 256B.69, subdivision 5, is amended to read:

Subd. 5. **Prospective per capita payment.** The commissioner shall establish the method and amount of payments for services. The commissioner shall annually contract

with demonstration providers to provide services consistent with these established methods and amounts for payment.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. For payments made during calendar year 1990 and later years, the commissioner shall contract with an independent actuary to establish prepayment rates.

By January 15, 1996, the commissioner shall report to the legislature on the methodology used to allocate to participating counties available administrative reimbursement for advocacy and enrollment costs. The report shall reflect the commissioner's judgment as to the adequacy of the funds made available and of the methodology for equitable distribution of the funds. The commissioner must involve participating counties in the development of the report.

Beginning July 1, 2004, the commissioner may include payments for elderly waiver services and 180 days of nursing home care in capitation payments for the prepaid medical assistance program for recipients age 65 and older. ~~Payments for elderly waiver services shall be made no earlier than the month following the month in which services were received.~~

ARTICLE 11

SPECIAL NEEDS BASIC CARE MEDICAID SERVICES

Section 1. Minnesota Statutes 2010, section 256B.69, subdivision 28, is amended to read:

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with demonstration providers and current or

18.1 former sponsors of qualified Medicare-approved special needs plans, to provide medical
18.2 assistance basic health care services to persons with disabilities, including those with
18.3 developmental disabilities. Basic health care services include:

18.4 (1) those services covered by the medical assistance state plan except for ICF/MR
18.5 services, home and community-based waiver services, case management for persons with
18.6 developmental disabilities under section 256B.0625, subdivision 20a, and personal care
18.7 and certain home care services defined by the commissioner in consultation with the
18.8 stakeholder group established under paragraph (d); and

18.9 (2) basic health care services may also include risk for up to 100 days of nursing
18.10 facility services for persons who reside in a noninstitutional setting and home health
18.11 services related to rehabilitation as defined by the commissioner after consultation with
18.12 the stakeholder group.

18.13 The commissioner may exclude other medical assistance services from the basic
18.14 health care benefit set. Enrollees in these plans can access any excluded services on the
18.15 same basis as other medical assistance recipients who have not enrolled.

18.16 Unless a person is otherwise required to enroll in managed care, enrollment in these
18.17 plans for Medicaid services must be voluntary. For purposes of this subdivision, automatic
18.18 enrollment with an option to opt out is not voluntary enrollment.

18.19 (b) Beginning January 1, 2007, the commissioner may contract with demonstration
18.20 providers and sponsors of qualified Medicare special needs plans, to provide basic
18.21 health care services under medical assistance to persons who are dually eligible for both
18.22 Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but
18.23 in the waiting period for Medicare. The commissioner shall consult with the stakeholder
18.24 group under paragraph (d) in developing program specifications for these services.
18.25 The commissioner shall report to the chairs of the house of representatives and senate
18.26 committees with jurisdiction over health and human services policy and finance by
18.27 February 1, 2007, on implementation of these programs and the need for increased funding
18.28 for the ombudsman for managed care and other consumer assistance and protections
18.29 needed due to enrollment in managed care of persons with disabilities. Payment for
18.30 Medicaid services provided under this subdivision for the months of May and June will
18.31 be made no earlier than July 1 of the same calendar year.

18.32 (c) Beginning January 1, 2008, the commissioner may expand contracting under this
18.33 subdivision to all persons with disabilities not otherwise required to enroll in managed
18.34 care.

18.35 (d) The commissioner shall establish a state-level stakeholder group to provide
18.36 advice on managed care programs for persons with disabilities, including both MnDHO

and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

- (1) implementation efforts;
 - (2) consumer protections; and
 - (3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.
- (e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.
- (f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner may mail marketing materials to potential enrollees on behalf of health plans, in which case the health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

ARTICLE 12

HEALTH SERVICES ADVISORY COUNCIL

Section 1. REVISOR'S INSTRUCTION.

The revisor shall change the term "Health Services Policy Committee" to "Health Services Advisory Council" wherever it appears in statutes.

ARTICLE 13

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS UNDER MINNESOTACARE

Section 1. Minnesota Statutes 2010, section 256B.199, is amended to read:

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

- (a) Effective July 1, 2007, the commissioner shall apply for federal matching funds for the expenditures in paragraphs (b) and (c). Effective July 1, 2011, the commissioner shall apply for matching funds for expenditures in paragraph (e).
- (b) The commissioner shall apply for federal matching funds for certified public expenditures as follows:
- (1) Hennepin County, Hennepin County Medical Center, Ramsey County, Regions Hospital, the University of Minnesota, and Fairview-University Medical Center shall

report quarterly to the commissioner beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law;

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

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

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

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

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

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

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

(d) For the period from April 1, 2009, to September 30, 2010, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the American Recovery and Reinvestment Act of 2009. These funds shall be made available as the state share of payments under section 256.969, subdivision 28.

The entities required to report certified public expenditures under paragraph (b), clause (1), shall report additional certified public expenditures as necessary under this paragraph.

(e) For services provided on or after July 1, 2011, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the MinnesotaCare program according to the requirements and conditions of paragraph (c).

Sec. 2. Minnesota Statutes 2010, section 256L.11, subdivision 6, is amended to read:

Subd. 6. **Enrollees 18 or older.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees eligible under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2,

21.1 with family gross income that exceeds 175 percent of the federal poverty guidelines
21.2 and who are not pregnant, who are 18 years old or older on the date of admission to the
21.3 inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults
21.4 who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and
21.5 whose incomes are equal to or less than 175 percent of the federal poverty guidelines,
21.6 shall be as provided for under paragraph (c).

21.7 (a) If the medical assistance rate minus any co-payment required under section
21.8 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's
21.9 benefit limit under section 256L.03, subdivision 3, payment must be the medical
21.10 assistance rate minus any co-payment required under section 256L.03, subdivision 4. The
21.11 hospital must not seek payment from the enrollee in addition to the co-payment. The
21.12 MinnesotaCare payment plus the co-payment must be treated as payment in full.

21.13 (b) If the medical assistance rate minus any co-payment required under section
21.14 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit
21.15 under section 256L.03, subdivision 3, payment must be the lesser of:

21.16 (1) the amount remaining in the enrollee's benefit limit; or

21.17 (2) charges submitted for the inpatient hospital services less any co-payment
21.18 established under section 256L.03, subdivision 4.

21.19 The hospital may seek payment from the enrollee for the amount by which usual and
21.20 customary charges exceed the payment under this paragraph. If payment is reduced under
21.21 section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the
21.22 enrollee for the amount of the reduction.

21.23 (c) For admissions occurring on or after July 1, 2011, for single adults and
21.24 households without children who are eligible under section 256L.04, subdivision 7, the
21.25 commissioner shall pay hospitals directly, up to the medical assistance payment rate,
21.26 for inpatient hospital benefits up to the \$10,000 annual inpatient benefit limit, minus
21.27 any co-payment required under section 256L.03, subdivision 5. Inpatient services paid
21.28 directly by the commissioner under this paragraph do not include chemical dependency
21.29 hospital-based and residential treatment.

21.30 **ARTICLE 14**

21.31 **MEDICAL ASSISTANCE PROVIDERS**

21.32 Section 1. Minnesota Statutes 2010, section 256B.02, is amended by adding a
21.33 subdivision to read:

21.34 Subd. 16. **Termination; terminate.** "Termination" or "terminate" for a provider
21.35 means a state Medicaid program or state children's health insurance program has taken an

22.1 action to revoke the provider's billing privileges, the provider has exhausted all appeal
22.2 rights or the timeline for appeal has expired, there is no expectation by the provider,
22.3 Medicaid program, or state children's health insurance program that the revocation is
22.4 temporary, the provider will be required to reenroll to reinstate billing privileges, and the
22.5 termination occurred for cause, including fraud, integrity, or quality.

22.6 Sec. 2. Minnesota Statutes 2010, section 256B.03, is amended by adding a subdivision
22.7 to read:

22.8 Subd. 4. **Prohibition on payments to providers outside of the United States.**

22.9 Payments for medical assistance must not be made:

22.10 (1) for services delivered or items supplied outside of the United States; or

22.11 (2) to a provider, financial institution, or entity located outside of the United States.

22.12 Sec. 3. Minnesota Statutes 2010, section 256B.03, is amended by adding a subdivision
22.13 to read:

22.14 Subd. 5. **Ordering or referring providers.** Claims for payments for supplies or
22.15 services that are based on an order or referral of a provider must include the ordering or
22.16 referring provider's national provider identifier (NPI). Claims for supplies or services
22.17 ordered or referred by a vendor who is not enrolled in medical assistance are not covered.

22.18 Sec. 4. Minnesota Statutes 2010, section 256B.04, is amended by adding a subdivision
22.19 to read:

22.20 Subd. 20. **Provider enrollment.** (a) If the commissioner determines that there is a
22.21 significant risk of fraudulent activity among a category of providers, the commissioner
22.22 may withhold payment from providers within that category upon initial enrollment for
22.23 a 90-day period. The withholding for each provider must begin on the date of the first
22.24 submission of a claim.

22.25 (b) The commissioner shall require, as a condition of enrollment in medical
22.26 assistance, that a provider within a particular industry sector or category establish a
22.27 compliance program that contains the core elements established by the Center for
22.28 Medicare and Medicaid Services.

22.29 (c) The commissioner may terminate the enrollment of an ordering or rendering
22.30 provider if the provider fails to maintain and, upon request from the commissioner,
22.31 provide access to documentation relating to written orders or requests for payment for
22.32 durable medical equipment, certifications for home health services, or referrals for other
22.33 items or services written or ordered by such provider.

23.1 (d) The commissioner shall terminate or deny the enrollment of any individual or
23.2 entity if the individual or entity has been terminated from participation in Medicare or
23.3 in any other state's health care program.

23.4 (e)(1) A provider who submits an application for enrollment shall disclose any
23.5 current or previous affiliation, direct or indirect, with a provider that has an unpaid debt to
23.6 any state or federal health care program, has been or is subject to a payment suspension
23.7 under a state or federal health care program, has been or is suspended, terminated, or
23.8 excluded from participation in a state or federal health care program, or has had its billing
23.9 privileges denied or revoked. "Affiliation" means a relationship where a person or entity
23.10 directly, or indirectly through one or more intermediaries, controls, or is controlled by, or
23.11 is under common control with the provider.

23.12 (2) If the commissioner determines that a previous affiliation in clause (1) poses an
23.13 undue risk of fraud, waste, or abuse, the commissioner may deny the application for
23.14 enrollment. The commissioner may revoke enrollment of a provider if the commissioner
23.15 determines that a provider failed to disclose an affiliation.

23.16 (f) As a condition of enrollment in medical assistance, the commissioner shall
23.17 require that a provider permit the Centers for Medicare and Medicaid Services, its agents,
23.18 or its designated contractors and the state agency, its agents, or its designated contractors
23.19 to conduct unannounced on-site inspections of any provider location.

23.20 (g) As a condition of enrollment in medical assistance, the commissioner shall
23.21 require that a provider consent to criminal background checks, including fingerprinting,
23.22 when required to do so under state law or by the level of screening based on risk of fraud,
23.23 waste, or abuse as determined for that category of provider.

23.24 (h) The commissioner may terminate the enrollment of and exclude from
23.25 participation any provider or individual for making or causing to be made any false
23.26 statement, omission, or misrepresentation of material fact in any application, agreement,
23.27 or contract to participate or enroll as a provider. The commissioner may impose civil
23.28 monetary penalties not to exceed \$50,000 for the conduct described in this paragraph. A
23.29 provider who is excluded, terminated, or subjected to civil monetary penalties under this
23.30 paragraph may request a contested case proceeding under section 256B.0643.

23.31 Sec. 5. Minnesota Statutes 2010, section 256B.064, subdivision 2, is amended to read:

23.32 Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner
23.33 shall determine any monetary amounts to be recovered and sanctions to be imposed upon
23.34 a vendor of medical care under this section. Except as provided in paragraphs (b) and
23.35 (d), neither a monetary recovery nor a sanction will be imposed by the commissioner

without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility, after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

(b) ~~Except for a nursing home or convalescent care facility,~~ when the commissioner finds good cause to suspend payments under Code of Federal Regulations, title 42, section 455.23(e) or (f), the commissioner ~~may~~ shall withhold or reduce payments to a vendor of medical care without providing advance notice of such withholding or reduction if either of the following occurs:

(1) the vendor is convicted of a crime involving the conduct described in subdivision 1a; or

(2) ~~the commissioner receives reliable evidence of fraud or willful misrepresentation by the vendor.~~ determines there is a credible allegation of fraud for which an investigation is pending under the program. A credible allegation of fraud is an allegation which has been verified by the state, from any source, including but not limited to:

(i) fraud hotline complaints;

(ii) claims data mining; and

(iii) patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have an indicia of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (b) within five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

(1) state that payments are being withheld according to paragraph (b);

(2) set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning an ongoing investigation;

~~(2)~~ (3) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;

~~(3)~~ (4) identify the types of claims to which the withholding applies; and

~~(4)~~ (5) inform the vendor of the right to submit written evidence for consideration by the commissioner.

The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud ~~or willful misrepresentation~~ by the vendor, or after legal proceedings relating to the alleged fraud ~~or willful misrepresentation~~ are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a).

(d) The commissioner ~~may~~ shall suspend or terminate a vendor's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the vendor's exclusion from participation in Medicare. Within five days of taking such action, the commissioner must send notice of the suspension or termination. The notice must:

(1) state that suspension or termination is the result of the vendor's exclusion from Medicare;

(2) identify the effective date of the suspension or termination; and

(3) inform the vendor of the need to be reinstated to Medicare before reapplying for participation in the program; ~~and~~

~~(4) inform the vendor of the right to submit written evidence for consideration by the commissioner.~~

(e) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the vendor. The appeal request must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;

(2) the computation that the vendor believes is correct;

(3) the authority in statute or rule upon which the vendor relies for each disputed item;

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(5) other information required by the commissioner.

Sec. 6. Minnesota Statutes 2010, section 256B.0641, subdivision 1, is amended to read:

Subdivision 1. **Recovery procedures; sources.** Notwithstanding section 256B.72 or any law or rule to the contrary, when the commissioner or the federal government

determines that an overpayment has been made by the state to any medical assistance vendor, the commissioner shall recover the overpayment as follows:

(1) if the federal share of the overpayment amount is due and owing to the federal government under federal law and regulations, the commissioner shall recover from the medical assistance vendor the federal share of the determined overpayment amount paid to that provider using the schedule of payments required by the federal government;

(2) if the overpayment to a medical assistance vendor is due to a retroactive adjustment made because the medical assistance vendor's temporary payment rate was higher than the established desk audit payment rate or because of a department error in calculating a payment rate, the commissioner shall recover from the medical assistance vendor the total amount of the overpayment within 120 days after the date on which written notice of the adjustment is sent to the medical assistance vendor or according to a schedule of payments approved by the commissioner; ~~and~~

(3) a medical assistance vendor is liable for the overpayment amount owed by a long-term care provider if the vendors or their owners are under common control or ownership; and

(4) in order to collect past due obligations to the department, the commissioner shall make any necessary adjustments to payments to a provider or vendor that has the same tax identification number as is assigned to a provider or vendor with past due obligations.

Sec. 7. Minnesota Statutes 2010, section 256B.27, subdivision 3, is amended to read:

Subd. 3. **Access to medical records.** The commissioner of human services, with the written consent of the recipient, on file with the local welfare agency, shall be allowed access to all personal medical records of medical assistance recipients solely for the purposes of investigating whether or not: ~~(a)~~ (1) a vendor of medical care has submitted a claim for reimbursement, a cost report or a rate application which is duplicative, erroneous, or false in whole or in part, or which results in the vendor obtaining greater compensation than the vendor is legally entitled to; or ~~(b)~~ (2) the medical care was medically necessary. ~~The vendor of medical care shall receive notification from the commissioner at least 24 hours before the commissioner gains access to such records.~~ The determination of provision of services not medically necessary shall be made by the commissioner. The commissioner may consult with an advisory task force of vendors the commissioner may appoint, on the recommendation of appropriate professional organizations. The task force expires as provided in section 15.059, subdivision 6. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal

27.1 liability for providing access to medical records to the commissioner of human services
27.2 pursuant to this section.

27.3 **ARTICLE 15**

27.4 **NONEMERGENCY MEDICAL TRANSPORTATION**

27.5 Section 1. **NONEMERGENCY MEDICAL TRANSPORTATION ADVISORY**
27.6 **COMMITTEE.**

27.7 (a) The commissioner of human services shall establish a nonemergency medical
27.8 transportation advisory committee. The nonemergency medical transportation advisory
27.9 committee shall advise the commissioner regarding the creation of a single administrative
27.10 structure for the coordination and management of nonemergency medical transportation
27.11 services provided under this chapter.

27.12 (b) Members must include, but are not limited to, representatives from the following:
27.13 Departments of Human Services and Transportation; Association of Minnesota Counties;
27.14 Metropolitan Council; ARC of Minnesota; Minnesota State Council on Disabilities;
27.15 transportation providers; managed care plans; skilled nursing facilities; a representative
27.16 from a metropolitan county and a rural county; and the National Alliance on Mental
27.17 Illness. The commissioner shall submit a proposal with draft legislation to the legislature
27.18 by January 15, 2012.

27.19 **ARTICLE 16**

27.20 **MANAGED CARE REPORTING**

27.21 Section 1. Minnesota Statutes 2010, section 13.461, subdivision 24a, is amended to
27.22 read:

27.23 Subd. 24a. **Managed care plans.** Data provided to the commissioner of human
27.24 services by managed care plans relating to contracts and provider payment rates are
27.25 classified under section 256B.69, subdivisions 9a and ~~9b~~ 9c.

27.26 Sec. 2. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision
27.27 to read:

27.28 Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect
27.29 detailed data regarding financials, provider payments, provider rate methodologies, and
27.30 other data as determined by the commissioner and managed care and county-based
27.31 purchasing plans that are required to be submitted under this section. The commissioner,
27.32 in consultation with the commissioners of health and commerce, shall set uniform criteria,

28.1 definitions, and standards for the data to be submitted, and shall require managed care and
28.2 county-based purchasing plans to comply with these criteria, definitions, and standards
28.3 when submitting data under this section.

28.4 (b) Each managed care and county-based purchasing plan must annually provide to
28.5 the commissioner, in the form and manner specified by the commissioner:

28.6 (1) administrative expenses by category and subcategory, by program;

28.7 (2) revenues by program, including investment income;

28.8 (3) nonadministrative service payments, provider payments, and reimbursement
28.9 rates by provider type or service category, by program, including but not limited to:

28.10 (i) individual-level provider payment and reimbursement rate data;

28.11 (ii) provider reimbursement rate methodologies by provider type, by program,
28.12 including health care home and total cost of care rate methodologies and other provider
28.13 total cost or risk-based arrangements;

28.14 (iii) data on legislatively mandated provider rate changes; and

28.15 (iv) plan-specific provider rate methodologies and individual-level or disaggregated
28.16 data provided to the commissioner under this subdivision are nonpublic data as defined in
28.17 section 13.02;

28.18 (4) data on the amount of reinsurance or transfer of risk by program; and

28.19 (5) contribution to reserve, by program.

28.20 **Sec. 3. REPEALER.**

28.21 Minnesota Statutes 2010, section 256B.69, subdivision 9b, is repealed.

APPENDIX
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256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

Subd. 18b. **Protections for American Indians.** Effective July 1, 2009, the commissioner shall comply with the federal requirements in the American Recovery and Reinvestment Act of 2009, Public Law 111-5, section 5006, regarding American Indians.

256B.69 PREPAID HEALTH PLANS.

Subd. 9b. **Reporting provider payment rates.** (a) According to guidelines developed by the commissioner, in consultation with health care providers, managed care plans, and county-based purchasing plans, each managed care plan and county-based purchasing plan must annually provide to the commissioner information on reimbursement rates paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan.

(b) Each managed care plan and county-based purchasing plan must annually provide to the commissioner, in the form and manner specified by the commissioner:

(1) the amount of the payment made to the plan under this section that is paid to health care providers for patient care;

(2) aggregate provider payment data, categorized by inpatient payments and outpatient payments, with the outpatient payments categorized by payments to primary care providers and nonprimary care providers;

(3) the process by which increases or decreases in payments made to the plan under this section, that are based on actuarial analysis related to provider cost increases or decreases, or that are required by legislative action, are passed through to health care providers, categorized by payments to primary care providers and nonprimary care providers; and

(4) specific information on the methodology used to establish provider reimbursement rates paid by the managed health care plan and county-based purchasing plan.

Data provided to the commissioner under this subdivision must allow the commissioner to conduct the analyses required under paragraph (d).

(c) Data provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02.

(d) The commissioner shall analyze data provided under this subdivision to assist the legislature in providing oversight and accountability related to expenditures under this section. The analysis must include information on payments to physicians, physician extenders, and hospitals, and may include other provider types as determined by the commissioner. The commissioner shall also array aggregate provider reimbursement rates by health plan, by primary care, and by nonprimary care categories. The commissioner shall report the analysis to the legislature annually, beginning December 15, 2010, and each December 15 thereafter. The commissioner shall also make this information available on the agency's Web site to managed care and county-based purchasing plans, health care providers, and the public.