A bill for an act

relating to human services; changing health care eligibility and application provisions for medical assistance, MinnesotaCare, and general assistance medical care; creating an Alzheimer's disease working groups; modifying claims processing practices; creating health care clearinghouses; encouraging primary caries prevention; requiring the commissioner to seek federal reimbursements and a federal waiver; requiring certain data; authorizing centers of excellence criteria; establishing a Drug Utilization Review Board; making technical changes; changing coinsurance provisions for MinnesotaCare; authorizing rulemaking; requiring a report; amending Minnesota Statutes 2008, sections 60A.23, subdivision 8; 62J.2930, subdivision 3; 245.494, subdivision 3; 256.015, subdivision 7; 256.969, subdivision 3a; 256B.037, subdivision 5; 256B.056, subdivisions 1c, 3c, 6; 256B.0625, subdivision 14, by adding subdivisions; 256B.094, subdivision 3; 256B.0951, by adding a subdivision; 256B.195, subdivisions 1, 2, 3; 256B.199; 256B.69, subdivision 5a; 256B.76, by adding a subdivision; 256B.77, subdivision 13; 256D.03, subdivision 3; 256L.03, subdivision 5; 256L.15, subdivision 2; Laws 2005, First Special Session chapter 4, article 8, sections 54; 61; 63; 66; 74; proposing coding for new law in Minnesota Statutes, chapter 62Q; repealing Minnesota Statutes 2008, sections 256B.031; 256L.01, subdivision 4; Laws 2005, First Special Session chapter 4, article 8, sections 21; 22; 23; 24.

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

Section 1. **ALZHEIMER'S DISEASE WORKING GROUP.**

Subdivision 1. **Establishment; members.** The Minnesota Board on Aging must convene an Alzheimer's disease working group that consists of no more than 20 members including, but not limited to:

(1) at least one caregiver of a person who has been diagnosed with Alzheimer's disease;

(2) at least one person who has been diagnosed with Alzheimer's disease;

(3) a representative of the nursing facility industry;

(4) a representative of the assisted living industry;

(5) a representative of the adult day services industry;

(6) a representative of the medical care provider community;

(7) a psychologist who specializes in dementia care;

(8) an Alzheimer's researcher;

(9) a representative of the Alzheimer's Association;

(10) the commissioner of human services or a designee;

(11) the commissioner of health or a designee;

(12) the ombudsman for long-term care or a designee; and

(13) at least two members named by the governor.

Subd. 2. **Duties; recommendations.** The Alzheimer's disease working group must examine the array of needs of individuals diagnosed with Alzheimer's disease, services available to meet these needs, and the capacity of the state and current providers to meet these and future needs. The working group shall consider and make recommendations on the following issues:

(1) trends in the state's Alzheimer's population and service needs including, but not limited to:

(i) the state's role in long-term care, family caregiver support, and assistance to persons with early-stage and early-onset of Alzheimer's disease;

(ii) state policy regarding persons with Alzheimer's disease and dementia; and

(iii) establishment of a surveillance system for the purpose of having proper estimates of the number of persons in the state with Alzheimer's disease, and the changing population with dementia;

(2) existing resources, services, and capacity including, but not limited to:

(i) type, cost, and availability of dementia services;

(ii) dementia-specific training requirements for long-term care staff;

(iii) quality care measures for residential care facilities;

(iv) availability of home and community-based resources for persons with Alzheimer's disease, including respite care;

(v) number and availability of long-term care dementia units;

(vi) adequacy and appropriateness of geriatric psychiatric units for persons with behavior disorders associated with Alzheimer's and related dementia; and

(vii) assisted living residential options for persons with dementia; and

(3) needed policies or responses including, but not limited to, the provision of coordinated services and supports to persons and families living with Alzheimer's and related disorders, the capacity to meet these needs, and strategies to address identified gaps in services.

Subd. 3. **Meetings.** At least four working group meetings must be public meetings, and to the extent practicable, technological means, such as Web casts, shall be used to reach the greatest number of people throughout the state.

Subd. 4. **Report.** The Board on Aging must submit a report and recommendations to the governor and chairs and ranking minority members of the legislative committees with jurisdiction over health care no later than January 15, 2011.

Subd. 5. **Private funding.** To the extent available, the Board on Aging may utilize funding provided by private foundations and other private funding sources to complete the duties of the Alzheimer's disease working group.

Subd. 6. **Sunset.** The Alzheimer's disease working group sunsets upon delivery of the required report to the governor and legislative committees.

Sec. 2. Minnesota Statutes 2008, section 60A.23, subdivision 8, is amended to read:

Subd. 8. **Self-insurance or insurance plan administrators who are vendors of risk management services.** (1) **Scope.** This subdivision applies to any vendor of risk management services and to any entity which administers, for compensation, a self-insurance or insurance plan. This subdivision does not apply (a) to an insurance company authorized to transact insurance in this state, as defined by section 60A.06, subdivision 1, clauses (4) and (5); (b) to a service plan corporation, as defined by section 62C.02, subdivision 6; (c) to a health maintenance organization, as defined by section 62D.02, subdivision 4; (d) to an employer directly operating a self-insurance plan for its employees' benefits; (e) to an entity which administers a program of health benefits established pursuant to a collective bargaining agreement between an employer, or group or association of employers, and a union or unions; or (f) to an entity which administers a self-insurance or insurance plan if a licensed Minnesota insurer is providing insurance to the plan and if the licensed insurer has appointed the entity administering the plan as one of its licensed agents within this state.

(2) **Definitions.** For purposes of this subdivision the following terms have the meanings given them.

(a) "Administering a self-insurance or insurance plan" means (i) processing, reviewing or paying claims, (ii) establishing or operating funds and accounts, or (iii) otherwise providing necessary administrative services in connection with the operation of a self-insurance or insurance plan.

(b) "Employer" means an employer, as defined by section 62E.02, subdivision 2.

(c) "Entity" means any association, corporation, partnership, sole proprietorship, trust, or other business entity engaged in or transacting business in this state.

(d) "Self-insurance or insurance plan" means a plan providing life, medical or hospital care, accident, sickness or disability insurance for the benefit of employees or members of an association, or a plan providing liability coverage for any other risk or hazard, which is or is not directly insured or provided by a licensed insurer, service plan corporation, or health maintenance organization.

(e) "Vendor of risk management services" means an entity providing for compensation actuarial, financial management, accounting, legal or other services for the purpose of designing and establishing a self-insurance or insurance plan for an employer.

(3) **License.** No vendor of risk management services or entity administering a self-insurance or insurance plan may transact this business in this state unless it is licensed to do so by the commissioner. An applicant for a license shall state in writing the type of activities it seeks authorization to engage in and the type of services it seeks authorization to provide. The license may be granted only when the commissioner is satisfied that the entity possesses the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered. The commissioner may issue a license subject to restrictions or limitations upon the authorization, including the type of services which may be supplied or the activities which may be engaged in. The license fee is $1,500 for the initial application and $1,500 for each three-year renewal. All licenses are for a period of three years.

(4) **Regulatory restrictions; powers of the commissioner.** To assure that self-insurance or insurance plans are financially solvent, are administered in a fair and equitable fashion, and are processing claims and paying benefits in a prompt, fair, and honest manner, vendors of risk management services and entities administering insurance or self-insurance plans are subject to the supervision and examination by the commissioner. Vendors of risk management services, entities administering insurance or self-insurance plans, and insurance or self-insurance plans established or operated by them are subject to the trade practice requirements of sections 72A.19 to 72A.30. In lieu of an unlimited guarantee from a parent corporation for a vendor of risk management services or an entity administering insurance or self-insurance plans, the commissioner may accept a surety bond in a form satisfactory to the commissioner in an amount equal to 120 percent of the total amount of claims handled by the applicant in the prior year. If at any time the total amount of claims handled during a year exceeds the amount upon which the bond was calculated, the administrator shall immediately notify the commissioner. The commissioner may require that the bond be increased accordingly.

No contract entered into after July 1, 2001, between a licensed vendor of risk management services and a group authorized to self-insure for workers' compensation

liabilities under section 79A.03, subdivision 6, may take effect until it has been filed with the commissioner, and either (1) the commissioner has approved it or (2) 60 days have elapsed and the commissioner has not disapproved it as misleading or violative of public policy.

(5) **Rulemaking authority.** To carry out the purposes of this subdivision, the commissioner may adopt rules pursuant to sections 14.001 to 14.69. These rules may:

(a) establish reporting requirements for administrators of insurance or self-insurance plans;

(b) establish standards and guidelines to assure the adequacy of financing, reinsuring, and administration of insurance or self-insurance plans;

(c) establish bonding requirements or other provisions assuring the financial integrity of entities administering insurance or self-insurance plans; or

(d) establish other reasonable requirements to further the purposes of this subdivision.

(6) **Claims processing practices.** No entity administering a self-insurance or insurance plan shall require a patient to pay for care provided by an in-network provider in an amount that exceeds the fee negotiated between the entity and that provider for the covered service provided.

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

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

(1) assist enrollees in understanding their rights;

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

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

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

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

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

(1) provide legal services to consumers;

(2) represent a consumer or enrollee; or

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

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

Sec. 4. **[62Q.7375] HEALTH CARE CLEARINGHOUSES.**

Subdivision 1. **Definition.** For the purposes of this section, "health care clearinghouse" or "clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that does either of the following functions:

(1) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or

(2) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

Subd. 2. **Claims submission deadlines and careful handling.** (a) A health plan or third-party administrator must not have or enforce a deadline for submission of claims that is shorter than the period provided in section 60A.23, subdivision 8, paragraph (6), clause (c).

(b) A claim submitted to a health plan or third-party administrator through a health care clearinghouse or clearinghouse within the time permitted under paragraph (a) must be treated as timely by the health plan or third-party administrator, provided it meets the requirements set forth in section 62Q.75, subdivision 1, paragraph (b). This paragraph does not apply if the provider submitted the claim to a clearinghouse that does not have the ability or authority to transmit the claim to the relevant health plan company.

EFFECTIVE DATE. This section is effective August 1, 2009, and applies to claims transmitted to a clearinghouse on or after that date.

Sec. 5. Minnesota Statutes 2008, section 245.494, subdivision 3, is amended to read:

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

(1) in the first quarter of 1994, in areas where a local children's mental health collaborative has been established, based on an independent actuarial analysis, identify all medical assistance and MinnesotaCare resources devoted to mental health services for children in the target population including inpatient, outpatient, medication management,

services under the rehabilitation option, and related physician services in the total health capitation of prepaid plans under contract with the commissioner to provide medical assistance services under section 256B.69;

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

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

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

(5) ensure that a children's mental health collaborative that receives resources passed through a prepaid health plan under contract with the commissioner shall be subject to the quality assurance standards, reporting of utilization information, standards set out in sections 245.487 to 245.4889, and other requirements established in Minnesota Rules, part 9500.1460;

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

(i) meets the requirements of section 245.4933;

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

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

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

(8) ensure that where a collaborative enters into an agreement with the commissioner to provide medical assistance and MinnesotaCare services a separate capitation rate will

be determined through an independent actuarial analysis which is based upon the factors set forth in clause (3) to be paid to a collaborative for children in the operational target population who are eligible for medical assistance but not included in the prepaid health plan contract with the commissioner;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 6. Minnesota Statutes 2008, section 256.015, subdivision 7, is amended to read:

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

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

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

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

(c) For the purpose of compliance with section 169.09, subdivision 13, and federal requirements under Code of Federal Regulations, title 42, section 433.138(d)(4), the commissioner of public safety shall provide accident data as requested by the commissioner of human services. The disclosure shall not violate section 169.09, subdivision 13, paragraph (d).

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

Sec. 7. Minnesota Statutes 2008, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and

256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after ~~July~~ August 1, 2005, made to hospitals

for inpatient services before third-party liability and spenddown, is reduced 6.0 percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical assistance does not include general assistance medical care. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2006, to reflect this reduction.

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

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

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

Sec. 8. Minnesota Statutes 2008, section 256B.037, subdivision 5, is amended to read:

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

Sec. 9. Minnesota Statutes 2008, section 256B.056, subdivision 1c, is amended to read:

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

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

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

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

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

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

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

Sec. 10. Minnesota Statutes 2008, section 256B.056, subdivision 3c, is amended to read:

Subd. 3c. **Asset limitations for families and children.** A household of two or more persons must not own more than $20,000 in total net assets, and a household of one person must not own more than $10,000 in total net assets. In addition to these maximum

amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

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

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

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

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

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

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

(7) assets owned by children are not considered.

Sec. 11. Minnesota Statutes 2008, section 256B.056, subdivision 6, is amended to read:

Subd. 6. **Assignment of benefits.** To be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person or the person's legal representative from any third party liable for the costs of medical care. By accepting or receiving assistance, the person is deemed to have assigned the person's rights to medical support and third party payments as required by title 19 of the Social Security Act. Persons must cooperate with the state in establishing paternity and obtaining third party payments. By accepting medical assistance, a person assigns to the Department of Human Services all rights the person may have to medical support or payments for medical expenses from any other person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. Any rights or amounts so assigned shall be applied against the cost of medical care paid for under this chapter. Any assignment takes effect upon the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant is determined eligible for and receives medical assistance benefits. The application must contain a statement explaining this assignment. For the purposes of this section, "the Department of Human Services or

the state" includes prepaid health plans under contract with the commissioner according to sections ~~256B.031,~~ 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing facilities under the alternative payment demonstration project under section 256B.434; and the county-based purchasing entities under section 256B.692.

Sec. 12. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

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

(7) establish and implement an ongoing process to:

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

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

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

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

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

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

Sec. 13. Minnesota Statutes 2008, section 256B.0625, subdivision 14, is amended to read:

Subd. 14. **Diagnostic, screening, and preventive services.** (a) Medical assistance covers diagnostic, screening, and preventive services.

(b) "Preventive services" include services related to pregnancy, including:

(1) services for those conditions which may complicate a pregnancy and which may be available to a pregnant woman determined to be at risk of poor pregnancy outcome;

(2) prenatal HIV risk assessment, education, counseling, and testing; and

(3) alcohol abuse assessment, education, and counseling on the effects of alcohol usage while pregnant. Preventive services available to a woman at risk of poor pregnancy outcome may differ in an amount, duration, or scope from those available to other individuals eligible for medical assistance.

(c) "Screening services" include, but are not limited to, blood lead tests.

(d) The commissioner shall encourage, at the time of the child and teen checkup or at an episodic care visit, the primary care health care provider to perform primary caries preventive services. Primary caries preventive services include, at a minimum:

(1) a general visual examination of the child's mouth without using probes or other dental equipment or taking radiographs;

(2) a risk assessment using the factors established by the American Academies of Pediatrics and Pediatric Dentistry; and

(3) the application of a fluoride varnish beginning at age 1 to those children assessed by the provider as being high risk in accordance with best practices as defined by the Department of Human Services.

At each checkup, if primary caries preventive services are provided, the provider must provide to the child's parent or legal guardian: information on caries etiology and prevention; and information on the importance of finding a dental home for their child by the age of 1. The provider must also advise the parent or legal guardian to contact the child's managed care plan or the Department of Human Services in order to secure a dental appointment with a dentist. The provider must indicate in the child's medical record that the parent or legal guardian was provided with this information and document any primary caries prevention services provided to the child.

Sec. 14. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

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

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

Sec. 15. Minnesota Statutes 2008, section 256B.094, subdivision 3, is amended to read:

Subd. 3. **Coordination and provision of services.** (a) In a county or reservation where a prepaid medical assistance provider has contracted under section ~~256B.031 or~~

256B.69 to provide mental health services, the case management provider shall coordinate with the prepaid provider to ensure that all necessary mental health services required under the contract are provided to recipients of case management services.

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

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

(d) If the county or tribal social services has not obtained prior authorization for this service, or an appeal results in a determination that the services were not medically necessary, the county or tribal social services may not seek reimbursement from the prepaid provider.

Sec. 16. Minnesota Statutes 2008, section 256B.0951, is amended by adding a subdivision to read:

Subd. 10. **Quality Assurance Commission federal reimbursement.** The commissioner shall seek federal financial participation for eligible activity by the Quality Assurance Commission performed for medical assistance recipients. The commission shall maintain and transmit to the commissioner documentation that is necessary to obtain federal funds. Any federal administrative and service reimbursement shall be provided to the commission for their statutory functions, minus administrative costs incurred by the commissioner.

Sec. 17. Minnesota Statutes 2008, section 256B.195, subdivision 1, is amended to read:

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

Sec. 18. Minnesota Statutes 2008, section 256B.195, subdivision 2, is amended to read:

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

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

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

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

Sec. 19. Minnesota Statutes 2008, section 256B.195, subdivision 3, is amended to read:

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

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

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

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

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

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

1997; and 26.1 percent shall be allocated to the commissioner of health for rural hospital capital improvement grants under section 144.148; and

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

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

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

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

(e) Effective July 1, 2003, if the amount available for allocation under paragraph (b) is greater than the amounts available during March 2003, after any increase in intergovernmental transfers and payments that result from section 256.969, subdivision 3a, paragraph (c), are paid to the general fund, any additional amounts available under this subdivision after reimbursement of the transfers under subdivision 2 shall be allocated to increase medical assistance payments, subject to hospital-specific charge limits and limits on disproportionate share hospital payments, as follows:

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

(2) if the payments under subdivision 5 are not approved, the amount shall be paid to the largest ten percent of hospitals as measured by 2001 payments for medical assistance, general assistance medical care, and MinnesotaCare in the nonstate government category and to the largest ten percent of hospitals as measured by payments for medical assistance, general assistance medical care, and MinnesotaCare in the nongovernment hospital

category. Payments shall be allocated according to each hospital's proportionate share of the 2001 payments in their respective category of nonstate government and nongovernment. The commissioner shall determine which hospitals are in the nonstate government and nongovernment hospital categories.

Sec. 20. Minnesota Statutes 2008, section 256B.199, is amended to read:

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

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

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

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

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

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

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

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

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

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

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

Sec. 21. Minnesota Statutes 2008, section 256B.69, subdivision 5a, is amended to read:

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

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

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section for the prepaid medical assistance and general assistance medical care programs pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23. A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

(d)(1) Effective for services rendered on or after January 1, 2009, the commissioner shall withhold three percent of managed care plan payments under this section for the prepaid medical assistance and general assistance medical care programs. The withheld

funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

Sec. 22. Minnesota Statutes 2008, section 256B.76, is amended by adding a subdivision to read:

Subd. 4a. **Designation and termination of critical access dental providers.** (a) The commissioner shall not designate an individual dentist or clinic as a critical access dental provider under subdivision 4 or section 256L.11, subdivision 7, when the owner or a dentist employed by or under contract with the practice:

(1) has been subject to a corrective or disciplinary action by the Minnesota Board of Dentistry within the past three years or is currently subject to a corrective or disciplinary action by the board. Designation shall not be made until the provider is no longer subject to a corrective or disciplinary action;

(2) when a group practice with multiple fixed clinic locations does not bill on a fixed clinic-specific location basis or bills using a critical access provider number for services provided at a noncritical access designated location;

(3) has been subject, within the past three years, to a post-investigation action by the commissioner of human services when investigating services provided to Minnesota health care program enrollees, including administrative sanctions, monetary recovery, referral to state regulatory agency, referral to the state attorney general or county attorney general, or issuance of a warning as specified in Minnesota Rules, parts 9505.2160 to 9505.2245. Designation shall not be considered until January of the year following documentation that the activity that resulted in post-investigative action has stopped; or

(4) has not completed the application for critical access dental provider designation, has submitted the application after the due date, has provided incorrect information, or has knowingly and willfully submitted a fraudulent designation form.

(b) The commissioner shall terminate a critical access designation of an individual dentist or clinic, if the owner or a dentist employed by or under contract with the practice:

(1) becomes subject to a disciplinary or corrective action by the Minnesota Board of Dentistry. The provider shall not be considered for critical access designation until January following the year in which the action has ended; or

(2) becomes subject to a post-investigation action by the commissioner of human services including administrative sanctions, monetary recovery, referral to state regulatory agency, referral to the state attorney general or county attorney general, or issuance of a warning as specified in Minnesota Rules, parts 9505.2160 to 9505.2245. Designation shall not be considered until January of the year following documentation that the activity that resulted in post-investigative action has stopped.

(c) Any termination is retroactive to the date of the:

(1) post-investigative action; or

(2) disciplinary or corrective action by the Minnesota Board of Dentistry.

(d) A provider who has been terminated or not designated may appeal only through the contested hearing process 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 notification of termination or non-designation.

(e) The commissioner may make an exception to paragraph (a), clauses (1) and (3), and paragraph (b), if an action taken by the Minnesota Board of Dentistry or the commissioner of human services is the result of a onetime event by an individual employed or contracted by a group practice.

(f) Post-investigative actions taken by contracted health plans shall be considered in the designation and termination of critical access providers.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 23. Minnesota Statutes 2008, section 256B.77, subdivision 13, is amended to read:

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

Sec. 24. Minnesota Statutes 2008, section 256D.03, subdivision 3, is amended to read:

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

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

(2) who is a resident of Minnesota; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(r) The commissioner shall seek approval for a federal waiver from the secretary of health and human services to create an optional medical assistance eligibility category of childless adults as a replacement for the general assistance medical care program. The optional category shall have a benefit set limited to those services described in subdivision 4. As part of the waiver application, the commissioner shall determine whether the complete elimination of state funding for general assistance medical care would result in higher costs for the federal Medicare program. As part of the waiver application, the commissioner may also consider the savings to the federal government due to state health care services provided to a similar population under section 256L.07, subdivision 6.

Individuals and households with no children who have gross family incomes that are equal to or less than 100 percent of the federal poverty guidelines shall be eligible for childless adult medical assistance effective July 1, 2011, or upon federal approval, whichever is later.

Sec. 25. Minnesota Statutes 2008, section 256L.03, subdivision 5, is amended to read:

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

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

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

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

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

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

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

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

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

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

Sec. 26. Minnesota Statutes 2008, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly

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

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

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

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

Federal Poverty Guideline Range	**Percent of Average Gross Monthly Income**
0-45%	minimum
46-54%	$4 or 1.1% of family income, whichever is greater

55-81%	1.6%
82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
165-191%	4.6%
192-219%	5.6%
220-248%	6.5%
~~249-274%~~ 249-275%	7.2%
~~275-300%~~	~~8.0%~~

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

Sec. 27. Laws 2005, First Special Session chapter 4, article 8, section 54, the effective date, is amended to read:

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

Sec. 28. Laws 2005, First Special Session chapter 4, article 8, section 61, the effective date, is amended to read:

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

Sec. 29. Laws 2005, First Special Session chapter 4, article 8, section 63, the effective date, is amended to read:

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

Sec. 30. Laws 2005, First Special Session chapter 4, article 8, section 66, the effective date, is amended to read:

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

Sec. 31. Laws 2005, First Special Session chapter 4, article 8, section 74, the effective date, is amended to read:

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

Sec. 32. **REPEALER.**

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

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

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