

1.1 A bill for an act

1.2 relating to health care; establishing mental health urgent care and consultation  
1.3 services; modifying the general assistance medical care program; appropriating  
1.4 money; amending Minnesota Statutes 2008, sections 256.9657, subdivisions 2,  
1.5 3; 256.969, subdivisions 21, 26, 27; 256B.0625, subdivisions 13f, 20, by adding  
1.6 a subdivision; 256B.69, by adding a subdivision; 256L.05, subdivisions 1b, 3,  
1.7 3a; 256L.07, subdivision 6; 256L.15, subdivision 4; 256L.17, subdivision 7;  
1.8 Minnesota Statutes 2009 Supplement, sections 256.969, subdivisions 2b, 3a, 30;  
1.9 256B.195, subdivision 3; 256D.03, subdivision 3; proposing coding for new law  
1.10 in Minnesota Statutes, chapters 245; 256D.

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

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

1.14 Subdivision 1. Mental health urgent care and psychiatric consultation. The  
1.15 commissioner shall include mental health urgent care and psychiatric consultation  
1.16 services as part of, but not limited to, the redesign of six community-based behavioral  
1.17 health hospitals and the Anoka-Metro Regional Treatment Center. These services must  
1.18 not duplicate existing services in the region, and must be implemented as specified in  
1.19 subdivisions 3 to 8.

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

1.21 (a) Mental health urgent care includes:

1.22 (1) initial mental health screening;

1.23 (2) mobile crisis assessment and intervention;

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

1.26 (4) nonhospital crisis stabilization residential beds;

2.1 (5) necessary psychiatric prescriptions from a qualified individual and assistance  
2.2 in obtaining psychiatric medications; and

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

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

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

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

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

2.14 (3) the commissioner may integrate rapid access to psychiatry with the psychiatric  
2.15 consultation services in subdivision 5.

2.16 Subd. 4. **Psychiatric medications.** The commissioner may develop a grant  
2.17 program to assist adults who are uninsured or otherwise unable to receive the psychiatric  
2.18 medications that they need, based on the following criteria:

2.19 (1) the individuals who are assisted must be at risk of publicly funded hospitalization;

2.20 (2) assistance with medications is for a limited time and must be transitioned to  
2.21 health care coverage as soon as possible; and

2.22 (3) the program may include co-pays based on the individual's ability to pay.

2.23 Subd. 5. **Collaborative psychiatric consultation.** The commissioner shall establish  
2.24 a collaborative psychiatric consultation service based on the following criteria:

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

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

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

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

2.33 Subd. 6. **Phased availability.** (a) The commissioner may phase in the availability  
2.34 of mental health urgent care services based on the limits of appropriations and the  
2.35 commissioner's determination of level of need and cost-effectiveness.

3.1 (b) For subdivisions 3 and 5, the first phase must focus on adults in Hennepin  
3.2 and Ramsey Counties and children statewide who are affected by section 256B.0625,  
3.3 subdivision 13j, and must include tracking of costs for the services provided and  
3.4 associated impacts on utilization of inpatient, emergency room, and other services.

3.5 Subd. 7. **Limited appropriations.** The commissioner shall maximize use  
3.6 of available health care coverage for the services provided under this section. The  
3.7 commissioner's responsibility to provide these services for individuals without health care  
3.8 coverage must not exceed the appropriations for this section.

3.9 Subd. 8. **Flexible implementation.** To implement this section, the commissioner  
3.10 shall select the structure and funding method that is the most cost-effective for each county  
3.11 or group of counties. This may include grants, contracts, direct provision by state-operated  
3.12 services, and public-private partnerships. Where feasible, the commissioner shall make  
3.13 any grants under this section a part of the integrated adult mental health initiative grants  
3.14 under section 245.4661.

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

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

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

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

3.28 (d) Notwithstanding the Medicare cost finding and allowable cost principles, the  
3.29 hospital surcharge is not an allowable cost for purposes of rate setting under sections  
3.30 256.9685 to 256.9695.

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

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

3.33 Subd. 3. **Surcharge on HMOs and community integrated service networks.** (a)  
3.34 Effective October 1, 1992, each health maintenance organization with a certificate of

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4.1 authority issued by the commissioner of health under chapter 62D and each community  
4.2 integrated service network licensed by the commissioner under chapter 62N shall pay to  
4.3 the commissioner of human services a surcharge equal to six-tenths of one percent of the  
4.4 total premium revenues of the health maintenance organization or community integrated  
4.5 service network as reported to the commissioner of health according to the schedule in  
4.6 subdivision 4.

4.7 (b) Effective March 1, 2010, to June 30, 2011: (1) the surcharge under paragraph (a)  
4.8 is increased to 4.0 percent; and (2) each county-based purchasing plan authorized under  
4.9 section 256B.692 shall pay to the commissioner a surcharge equal to 3.4 percent of the  
4.10 total premium revenues of the plan, as reported to the commissioner of health, according  
4.11 to the payment schedule in subdivision 4. Notwithstanding section 256.9656, money  
4.12 collected under this paragraph in excess of the amount collected under paragraph (a) shall  
4.13 be deposited in the account established in section 256D.032.

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

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

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

4.22 (3) Medicare revenue, as a result of an arrangement between a health maintenance  
4.23 organization or a community integrated service network and the Centers for Medicare  
4.24 and Medicaid Services of the federal Department of Health and Human Services, for  
4.25 services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited  
4.26 from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social  
4.27 Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and  
4.28 1395w-24, respectively, as they may be amended from time to time; and

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

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

4.35 ~~(e)~~ (d) When a health maintenance organization or community integrated service  
4.36 network merges or consolidates with or is acquired by another health maintenance

5.1 organization or community integrated service network, the surviving corporation or the  
5.2 new corporation shall be responsible for the annual surcharge originally imposed on  
5.3 each of the entities or corporations subject to the merger, consolidation, or acquisition,  
5.4 regardless of whether one of the entities or corporations does not retain a certificate of  
5.5 authority under chapter 62D or a license under chapter 62N.

5.6 ~~(d)~~ (e) Effective July 1 of each year, the surviving corporation's or the new  
5.7 corporation's surcharge shall be based on the revenues earned in the second previous  
5.8 calendar year by all of the entities or corporations subject to the merger, consolidation,  
5.9 or acquisition regardless of whether one of the entities or corporations does not retain a  
5.10 certificate of authority under chapter 62D or a license under chapter 62N until the total  
5.11 premium revenues of the surviving corporation include the total premium revenues of all  
5.12 the merged entities as reported to the commissioner of health.

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

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

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

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

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

5.30 Subd. 2b. **Operating payment rates.** In determining operating payment rates for  
5.31 admissions occurring on or after the rate year beginning January 1, 1991, and every two  
5.32 years after, or more frequently as determined by the commissioner, the commissioner shall  
5.33 obtain operating data from an updated base year and establish operating payment rates  
5.34 per admission for each hospital based on the cost-finding methods and allowable costs of  
5.35 the Medicare program in effect during the base year. Rates under the general assistance

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6.1 medical care, medical assistance, and MinnesotaCare programs shall not be rebased to  
6.2 more current data on January 1, 1997, January 1, 2005, for the first 24 months of the  
6.3 rebased period beginning January 1, 2009. For the first ~~three~~ six months of the rebased  
6.4 period beginning January 1, 2011, rates shall not be rebased ~~at 74.25 percent of the full~~  
6.5 ~~value of the rebasing percentage change~~. From ~~April~~ July 1, 2011, to March 31, 2012,  
6.6 rates shall be rebased at 39.2 percent of the full value of the rebasing percentage change.  
6.7 Effective April 1, 2012, rates shall be rebased at full value. The base year operating  
6.8 payment rate per admission is standardized by the case mix index and adjusted by the  
6.9 hospital cost index, relative values, and disproportionate population adjustment. The  
6.10 cost and charge data used to establish operating rates shall only reflect inpatient services  
6.11 covered by medical assistance and shall not include property cost information and costs  
6.12 recognized in outlier payments.

6.13 Sec. 5. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 3a, is  
6.14 amended to read:

6.15 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical  
6.16 assistance program must not be submitted until the recipient is discharged. However,  
6.17 the commissioner shall establish monthly interim payments for inpatient hospitals that  
6.18 have individual patient lengths of stay over 30 days regardless of diagnostic category.  
6.19 Except as provided in section 256.9693, medical assistance reimbursement for treatment  
6.20 of mental illness shall be reimbursed based on diagnostic classifications. Individual  
6.21 hospital payments established under this section and sections 256.9685, 256.9686, and  
6.22 256.9695, in addition to third party and recipient liability, for discharges occurring during  
6.23 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered  
6.24 inpatient services paid for the same period of time to the hospital. This payment limitation  
6.25 shall be calculated separately for medical assistance and general assistance medical  
6.26 care services. The limitation on general assistance medical care shall be effective for  
6.27 admissions occurring on or after July 1, 1991. Services that have rates established under  
6.28 subdivision 11 or 12, must be limited separately from other services. After consulting with  
6.29 the affected hospitals, the commissioner may consider related hospitals one entity and  
6.30 may merge the payment rates while maintaining separate provider numbers. The operating  
6.31 and property base rates per admission or per day shall be derived from the best Medicare  
6.32 and claims data available when rates are established. The commissioner shall determine  
6.33 the best Medicare and claims data, taking into consideration variables of recency of the  
6.34 data, audit disposition, settlement status, and the ability to set rates in a timely manner.  
6.35 The commissioner shall notify hospitals of payment rates by December 1 of the year

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7.1 preceding the rate year. The rate setting data must reflect the admissions data used to  
7.2 establish relative values. Base year changes from 1981 to the base year established for the  
7.3 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited  
7.4 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision  
7.5 1. The commissioner may adjust base year cost, relative value, and case mix index data  
7.6 to exclude the costs of services that have been discontinued by the October 1 of the year  
7.7 preceding the rate year or that are paid separately from inpatient services. Inpatient stays  
7.8 that encompass portions of two or more rate years shall have payments established based  
7.9 on payment rates in effect at the time of admission unless the date of admission preceded  
7.10 the rate year in effect by six months or more. In this case, operating payment rates for  
7.11 services rendered during the rate year in effect and established based on the date of  
7.12 admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

7.21 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for  
7.22 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for  
7.23 inpatient services before third-party liability and spenddown, is reduced 6.0 percent  
7.24 from the current statutory rates. Mental health services within diagnosis related groups  
7.25 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.  
7.26 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical  
7.27 assistance does not include general assistance medical care. Payments made to managed  
7.28 care plans shall be reduced for services provided on or after January 1, 2006, to reflect  
7.29 this reduction.

7.30 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for  
7.31 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made  
7.32 to hospitals for inpatient services before third-party liability and spenddown, is reduced  
7.33 3.46 percent from the current statutory rates. Mental health services with diagnosis related  
7.34 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this  
7.35 paragraph. Payments made to managed care plans shall be reduced for services provided  
7.36 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

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8.1 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for  
8.2 fee-for-service admissions occurring on or after July 1, 2009, through June 30, ~~2010~~ 2011,  
8.3 made to hospitals for inpatient services before third-party liability and spenddown, is  
8.4 reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis  
8.5 related groups 424 to 432 and facilities defined under subdivision 16 are excluded from  
8.6 this paragraph. Payments made to managed care plans shall be reduced for services  
8.7 provided on or after July 1, 2009, through June 30, ~~2010~~ 2011, to reflect this reduction.

8.8 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment  
8.9 for fee-for-service admissions occurring on or after July 1, ~~2010~~ 2011, made to hospitals  
8.10 for inpatient services before third-party liability and spenddown, is reduced 1.79 percent  
8.11 from the current statutory rates. Mental health services with diagnosis related groups  
8.12 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.  
8.13 Payments made to managed care plans shall be reduced for services provided on or after  
8.14 July 1, ~~2010~~ 2011, to reflect this reduction.

8.15 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total  
8.16 payment for fee-for-service admissions occurring on or after July 1, 2009, made to  
8.17 hospitals for inpatient services before third-party liability and spenddown, is reduced  
8.18 one percent from the current statutory rates. Facilities defined under subdivision 16 are  
8.19 excluded from this paragraph. Payments made to managed care plans shall be reduced for  
8.20 services provided on or after October 1, 2009, to reflect this reduction.

8.21 (i) In order to offset the ratable reductions provided for in this subdivision, the  
8.22 base payment rate prior to case mix adjustments for fee-for-service admissions occurring  
8.23 from March 1, 2010, to June 30, 2011, made to hospitals for inpatient services before  
8.24 third-party liability and spenddown, shall be increased by 15 percent from the current  
8.25 statutory rates. For purposes of this paragraph, medical assistance does not include  
8.26 general assistance medical care. This increase shall be paid from the account established  
8.27 in section 256D.032. The commissioner shall not adjust rates paid to a prepaid health plan  
8.28 under contract with the commissioner to reflect payments provided in this paragraph. The  
8.29 commissioner may utilize a settlement process to adjust rates in excess of the Medicare  
8.30 upper limits on payments. The commissioner may ratably reduce payments under this  
8.31 paragraph in order to comply with section 256B.195, subdivision 3, paragraph (f).

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

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

8.34 Subd. 21. **Mental health or chemical dependency admissions; rates.** (a)  
8.35 Admissions under the general assistance medical care program occurring on or after

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9.1 July 1, 1990, and admissions under medical assistance, excluding general assistance  
9.2 medical care, occurring on or after July 1, 1990, and on or before September 30, 1992,  
9.3 that are classified to a diagnostic category of mental health or chemical dependency  
9.4 shall have rates established according to the methods of subdivision 14, except the per  
9.5 day rate shall be multiplied by a factor of 2, provided that the total of the per day rates  
9.6 shall not exceed the per admission rate. This methodology shall also apply when a hold  
9.7 or commitment is ordered by the court for the days that inpatient hospital services are  
9.8 medically necessary. Stays which are medically necessary for inpatient hospital services  
9.9 and covered by medical assistance shall not be billable to any other governmental entity.  
9.10 Medical necessity shall be determined under criteria established to meet the requirements  
9.11 of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b).

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

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

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

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

9.32 (1) the hospital's current payment rate for the diagnostic category to which the  
9.33 diagnosis-related group belongs, exclusive of disproportionate population adjustments  
9.34 received under subdivision 9 and hospital payment adjustments received under subdivision  
9.35 23; or

10.1 (2) 90 percent of the average payment rate for that diagnostic category for hospitals  
10.2 located within the seven-county metropolitan area, exclusive of disproportionate  
10.3 population adjustments received under subdivision 9 and hospital payment adjustments  
10.4 received under subdivisions 20 and 23.

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

- 10.7 (1) 370 cesarean section with complicating diagnosis;
- 10.8 (2) 371 cesarean section without complicating diagnosis;
- 10.9 (3) 372 vaginal delivery with complicating diagnosis;
- 10.10 (4) 373 vaginal delivery without complicating diagnosis;
- 10.11 (5) 386 extreme immaturity and respiratory distress syndrome, neonate;
- 10.12 (6) 388 full-term neonates with other problems;
- 10.13 (7) 390 prematurity without major problems;
- 10.14 (8) 391 normal newborn;
- 10.15 (9) 385 neonate, died or transferred to another acute care facility;
- 10.16 (10) 425 acute adjustment reaction and psychosocial dysfunction;
- 10.17 (11) 430 psychoses;
- 10.18 (12) 431 childhood mental disorders; and
- 10.19 (13) 164-167 appendectomy.

10.20 (c) For admissions occurring from March 1, 2010, to June 30, 2011, the payment  
10.21 rate under paragraph (a), clause (2), shall be increased to 100 percent from 90 percent,  
10.22 after application of the rate increase in subdivision 3a, paragraph (i). This increase shall  
10.23 be paid from the account established in section 256D.032. The commissioner shall not  
10.24 adjust rates paid to a prepaid health plan under contract with the commissioner to reflect  
10.25 payments provided in this paragraph. The commissioner may utilize a settlement process  
10.26 to adjust rates in excess of the Medicare upper limits on payments. The commissioner may  
10.27 ratably reduce payments under this paragraph in order to comply with section 256B.195,  
10.28 subdivision 3, paragraph (f).

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

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

10.31 Subd. 27. **Quarterly payment adjustment.** (a) In addition to any other payment  
10.32 under this section, the commissioner shall make the following payments effective July  
10.33 1, 2007:

- 10.34 (1) for a hospital located in Minnesota and not eligible for payments under  
10.35 subdivision 20, with a medical assistance inpatient utilization rate greater than 17.8

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11.1 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal  
11.2 to 13 percent of the total of the operating and property payment rates;

11.3 (2) for a hospital located in Minnesota in a specified urban area outside of the  
11.4 seven-county metropolitan area and not eligible for payments under subdivision 20, with  
11.5 a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total  
11.6 patient days as of the base year in effect on July 1, 2005, a payment equal to ten percent  
11.7 of the total of the operating and property payment rates. For purposes of this clause, the  
11.8 following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Alexandria,  
11.9 Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids,  
11.10 Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena;

11.11 (3) for a hospital located in Minnesota but not located in a specified urban area  
11.12 under clause (2), with a medical assistance inpatient utilization rate less than or equal to  
11.13 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment  
11.14 equal to four percent of the total of the operating and property payment rates. A hospital  
11.15 located in Woodbury and not in existence during the base year shall be reimbursed under  
11.16 this clause; and

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

11.28 (b) The state share of payments under paragraph (a) shall be equal to federal  
11.29 reimbursements to the commissioner to reimburse expenditures reported under section  
11.30 256B.199. The commissioner shall ratably reduce or increase payments under this  
11.31 subdivision in order to ensure that these payments equal the amount of reimbursement  
11.32 received by the commissioner under section 256B.199, except that payments shall be  
11.33 ratably reduced by an amount equivalent to the state share of a four percent reduction in  
11.34 MinnesotaCare and medical assistance payments for inpatient hospital services. Effective  
11.35 July 1, 2009, the ratable reduction shall be equivalent to the state share of a three percent  
11.36 reduction in these payments. Effective for federal disproportionate share hospital funds

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12.1 earned on general assistance medical care payments for services rendered March 1, 2010,  
12.2 to June 30, 2011, the amount of the three percent ratable reduction required under this  
12.3 paragraph shall be deposited in the account established in section 256D.032.

12.4 (c) The payments under paragraph (a) shall be paid quarterly based on each hospital's  
12.5 operating and property payments from the second previous quarter, beginning on July  
12.6 15, 2007, or upon federal approval of federal reimbursements under section 256B.199,  
12.7 whichever occurs later.

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

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

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

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

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

12.25 Subd. 30. **Payment rates for births.** (a) For admissions occurring on or after  
12.26 October 1, 2009, the total operating and property payment rate, excluding disproportionate  
12.27 population adjustment, for the following diagnosis-related groups, as they fall within  
12.28 the diagnostic categories: (1) 371 cesarean section without complicating diagnosis; (2)  
12.29 372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without  
12.30 complicating diagnosis, shall be no greater than \$3,528.

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

12.32 (c) Payments to managed care and county-based purchasing plans under section  
12.33 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October  
12.34 1, 2009, to reflect the adjustments in paragraph (a).

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

13.3 (e) In order to ensure adequate access for the provision of maternity services and  
13.4 to encourage broader delivery of these services outside the nonstate governmental  
13.5 hospital setting, payment rates for medical assistance admissions, excluding general  
13.6 assistance medical care admissions, occurring from March 1, 2010, to June 30, 2011,  
13.7 at a private, not-for-profit hospital above the 65th percentile of all Minnesota private,  
13.8 nonprofit hospitals in terms of deliveries paid by medical assistance, shall be increased for  
13.9 diagnosis-related groups 370 to 373, 388, 390, and 391 at a percentage calculated to cost  
13.10 not more than a total of \$42,000,000, including state and federal shares. This increase shall  
13.11 be paid from the account established in section 256D.032. The commissioner shall not  
13.12 adjust rates paid to a prepaid health plan under contract with the commissioner to reflect  
13.13 payments provided in this paragraph. The commissioner may utilize a settlement process  
13.14 to adjust rates in excess of the Medicare upper limits on payments. The commissioner may  
13.15 ratably reduce payments under this paragraph in order to comply with section 256B.195,  
13.16 subdivision 3, paragraph (f).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14.21 (e) The commissioner may require prior authorization for brand name drugs  
14.22 whenever a generically equivalent product is available, even if the prescriber specifically  
14.23 indicates "dispense as written-brand necessary" on the prescription as required by section  
14.24 151.21, subdivision 2.

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

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

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

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

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

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

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

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

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

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

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

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

15.32 Sec. 12. Minnesota Statutes 2008, section 256B.0625, subdivision 20, is amended to  
15.33 read:

15.34 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule  
15.35 of the state agency, medical assistance covers case management services to persons with

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16.1 serious and persistent mental illness and children with severe emotional disturbance.  
16.2 Services provided under this section must meet the relevant standards in sections 245.461  
16.3 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota  
16.4 Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

16.5 (b) Entities meeting program standards set out in rules governing family community  
16.6 support services as defined in section 245.4871, subdivision 17, are eligible for medical  
16.7 assistance reimbursement for case management services for children with severe  
16.8 emotional disturbance when these services meet the program standards in Minnesota  
16.9 Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

16.10 (c) Medical assistance and MinnesotaCare payment for mental health case  
16.11 management shall be made on a monthly basis. In order to receive payment for an eligible  
16.12 child, the provider must document at least a face-to-face contact with the child, the child's  
16.13 parents, or the child's legal representative. To receive payment for an eligible adult, the  
16.14 provider must document:

16.15 (1) at least a face-to-face contact with the adult or the adult's legal representative; or

16.16 (2) at least a telephone contact with the adult or the adult's legal representative and  
16.17 document a face-to-face contact with the adult or the adult's legal representative within  
16.18 the preceding two months.

16.19 (d) Payment for mental health case management provided by county or state staff  
16.20 shall be based on the monthly rate methodology under section 256B.094, subdivision 6,  
16.21 paragraph (b), with separate rates calculated for child welfare and mental health, and  
16.22 within mental health, separate rates for children and adults.

16.23 (e) Payment for mental health case management provided by Indian health services  
16.24 or by agencies operated by Indian tribes may be made according to this section or other  
16.25 relevant federally approved rate setting methodology.

16.26 (f) Payment for mental health case management provided by vendors who contract  
16.27 with a county or Indian tribe shall be based on a monthly rate negotiated by the host county  
16.28 or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same  
16.29 service to other payers. If the service is provided by a team of contracted vendors, the  
16.30 county or tribe may negotiate a team rate with a vendor who is a member of the team. The  
16.31 team shall determine how to distribute the rate among its members. No reimbursement  
16.32 received by contracted vendors shall be returned to the county or tribe, except to reimburse  
16.33 the county or tribe for advance funding provided by the county or tribe to the vendor.

16.34 (g) If the service is provided by a team which includes contracted vendors, tribal  
16.35 staff, and county or state staff, the costs for county or state staff participation in the team  
16.36 shall be included in the rate for county-provided services. In this case, the contracted

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17.1 vendor, the tribal agency, and the county may each receive separate payment for services  
17.2 provided by each entity in the same month. In order to prevent duplication of services,  
17.3 each entity must document, in the recipient's file, the need for team case management and  
17.4 a description of the roles of the team members.

17.5 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs  
17.6 for mental health case management shall be provided by the recipient's county of  
17.7 responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal  
17.8 funds or funds used to match other federal funds. If the service is provided by a tribal  
17.9 agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this  
17.10 service is paid by the state without a federal share through fee-for-service, 50 percent of  
17.11 the cost shall be provided by the recipient's county of responsibility, unless the service  
17.12 is provided under the general assistance medical care program established in section  
17.13 256D.031.

17.14 (i) Notwithstanding any administrative rule to the contrary, prepaid medical  
17.15 assistance, general assistance medical care, and MinnesotaCare include mental health case  
17.16 management. When the service is provided through prepaid capitation, the nonfederal  
17.17 share is paid by the state and the county pays no share.

17.18 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a  
17.19 provider that does not meet the reporting or other requirements of this section. The county  
17.20 of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal  
17.21 agency, is responsible for any federal disallowances. The county or tribe may share this  
17.22 responsibility with its contracted vendors.

17.23 (k) The commissioner shall set aside a portion of the federal funds earned for county  
17.24 expenditures under this section to repay the special revenue maximization account under  
17.25 section 256.01, subdivision 2, clause (15). The repayment is limited to:

17.26 (1) the costs of developing and implementing this section; and

17.27 (2) programming the information systems.

17.28 (l) Payments to counties and tribal agencies for case management expenditures  
17.29 under this section shall only be made from federal earnings from services provided  
17.30 under this section. When this service is paid by the state without a federal share through  
17.31 fee-for-service, 50 percent of the cost shall be provided by the state. Payments to  
17.32 county-contracted vendors shall include the federal earnings, the state share, and the  
17.33 county share.

17.34 (m) Case management services under this subdivision do not include therapy,  
17.35 treatment, legal, or outreach services.

18.1 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or  
18.2 hospital, and the recipient's institutional care is paid by medical assistance, payment for  
18.3 case management services under this subdivision is limited to the lesser of:

18.4 (1) the last 180 days of the recipient's residency in that facility and may not exceed  
18.5 more than six months in a calendar year; or

18.6 (2) the limits and conditions which apply to federal Medicaid funding for this service.

18.7 (o) Payment for case management services under this subdivision shall not duplicate  
18.8 payments made under other program authorities for the same purpose.

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

18.10 Sec. 13. Minnesota Statutes 2009 Supplement, section 256B.195, subdivision 3,  
18.11 is amended to read:

18.12 Subd. 3. **Payments to certain safety net providers.** (a) Effective July 15, 2001, the  
18.13 commissioner shall make the following payments to the hospitals indicated annually:

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

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

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

18.25 (1) 18 percent, plus any federal matching funds, shall be allocated for the following  
18.26 purposes:

18.27 (i) during the fiscal year beginning July 1, 2001, of the amount available under  
18.28 this clause, 39.7 percent shall be allocated to make increased hospital payments under  
18.29 section 256.969, subdivision 26; 34.2 percent shall be allocated to fund the amounts  
18.30 due from small rural hospitals, as defined in section 144.148, for overpayments under  
18.31 section 256.969, subdivision 5a, resulting from a determination that medical assistance  
18.32 and general assistance payments exceeded the charge limit during the period from 1994 to  
18.33 1997; and 26.1 percent shall be allocated to the commissioner of health for rural hospital  
18.34 capital improvement grants under section 144.148; and

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

19.5 (2) 11 percent shall be allocated to the commissioner of health to fund community  
19.6 clinic grants under section 145.9268.

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

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

19.18 (e) Effective July 1, 2003, if the amount available for allocation under paragraph  
19.19 (b) is greater than the amounts available during March 2003, after any increase in  
19.20 intergovernmental transfers and payments that result from section 256.969, subdivision  
19.21 3a, paragraph (c), are paid to the general fund, any additional amounts available under this  
19.22 subdivision after reimbursement of the transfers under subdivision 2 shall be allocated to  
19.23 increase medical assistance payments, subject to hospital-specific charge limits and limits  
19.24 on disproportionate share hospital payments, as follows:

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

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

20.1 nongovernment. The commissioner shall determine which hospitals are in the nonstate  
20.2 government and nongovernment hospital categories.

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

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

20.6 Sec. 14. Minnesota Statutes 2008, section 256B.69, is amended by adding a  
20.7 subdivision to read:

20.8 Subd. 5k. **Temporary rate modifications.** For services rendered effective May 1,  
20.9 2010, to June 30, 2011, the total payment made to managed care plans under the medical  
20.10 assistance program shall be increased by 5.14 percent. This increase shall be paid from the  
20.11 account established in section 256D.032.

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

20.13 Sec. 15. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, is  
20.14 amended to read:

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

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

20.23 (2) who is a resident of Minnesota; and

20.24 (i) who has gross countable income not in excess of 75 percent of the federal poverty  
20.25 guidelines for the family size, using a six-month budget period and whose equity in assets  
20.26 is not in excess of \$1,000 per assistance unit. General assistance medical care is not  
20.27 available for applicants or enrollees who are otherwise eligible for medical assistance but  
20.28 fail to verify their assets. Enrollees who become eligible for medical assistance shall be  
20.29 terminated and transferred to medical assistance. Exempt assets, the reduction of excess  
20.30 assets, and the waiver of excess assets must conform to the medical assistance program in  
20.31 section 256B.056, subdivisions 3 and 3d, with the following exception: the maximum  
20.32 amount of undistributed funds in a trust that could be distributed to or on behalf of the

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21.1 beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the  
21.2 terms of the trust, must be applied toward the asset maximum; or

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

21.7 (b) The commissioner shall adjust the income standards under this section each July  
21.8 1 by the annual update of the federal poverty guidelines following publication by the  
21.9 United States Department of Health and Human Services.

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

21.14 (d) Effective for applications and renewals processed on or after September 1, 2006,  
21.15 general assistance medical care may be paid for applicants and recipients who meet all  
21.16 eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period  
21.17 beginning the date of application. Immediately following approval of general assistance  
21.18 medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04,  
21.19 subdivision 7, with covered services as provided in section 256L.03 for the rest of the  
21.20 six-month general assistance medical care eligibility period, until their six-month renewal.

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

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

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

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

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

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

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

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

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

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

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

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

22.16 (i) The date of an initial Minnesota health care program application necessary to  
22.17 begin a determination of eligibility shall be the date the applicant has provided a name,  
22.18 address, and Social Security number, signed and dated, to the county agency or the  
22.19 Department of Human Services. If the applicant is unable to provide a name, address,  
22.20 Social Security number, and signature when health care is delivered due to a medical  
22.21 condition or disability, a health care provider may act on an applicant's behalf to establish  
22.22 the date of an initial Minnesota health care program application by providing the county  
22.23 agency or Department of Human Services with provider identification and a temporary  
22.24 unique identifier for the applicant. The applicant must complete the remainder of the  
22.25 application and provide necessary verification before eligibility can be determined. The  
22.26 applicant must complete the application within the time periods required under the  
22.27 medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart  
22.28 5, and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining  
22.29 verification if necessary.

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

22.34 (k) General assistance medical care is not available for a person in a correctional  
22.35 facility unless the person is detained by law for less than one year in a county correctional  
22.36 or detention facility as a person accused or convicted of a crime, or admitted as an

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23.1 inpatient to a hospital on a criminal hold order, and the person is a recipient of general  
23.2 assistance medical care at the time the person is detained by law or admitted on a criminal  
23.3 hold order and as long as the person continues to meet other eligibility requirements  
23.4 of this subdivision.

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

23.7 (m) In determining the amount of assets of an individual eligible under paragraph  
23.8 (a), clause (2), item (i), there shall be included any asset or interest in an asset, including  
23.9 an asset excluded under paragraph (a), that was given away, sold, or disposed of for  
23.10 less than fair market value within the 60 months preceding application for general  
23.11 assistance medical care or during the period of eligibility. Any transfer described in this  
23.12 paragraph shall be presumed to have been for the purpose of establishing eligibility for  
23.13 general assistance medical care, unless the individual furnishes convincing evidence to  
23.14 establish that the transaction was exclusively for another purpose. For purposes of this  
23.15 paragraph, the value of the asset or interest shall be the fair market value at the time it  
23.16 was given away, sold, or disposed of, less the amount of compensation received. For any  
23.17 uncompensated transfer, the number of months of ineligibility, including partial months,  
23.18 shall be calculated by dividing the uncompensated transfer amount by the average monthly  
23.19 per person payment made by the medical assistance program to skilled nursing facilities  
23.20 for the previous calendar year. The individual shall remain ineligible until this fixed period  
23.21 has expired. The period of ineligibility may exceed 30 months, and a reapplication for  
23.22 benefits after 30 months from the date of the transfer shall not result in eligibility unless  
23.23 and until the period of ineligibility has expired. The period of ineligibility begins in the  
23.24 month the transfer was reported to the county agency, or if the transfer was not reported,  
23.25 the month in which the county agency discovered the transfer, whichever comes first. For  
23.26 applicants, the period of ineligibility begins on the date of the first approved application.

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

23.32 (o) Undocumented noncitizens and nonimmigrants are ineligible for general  
23.33 assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual  
23.34 in one or more of the classes listed in United States Code, title 8, section 1101, subsection  
23.35 (a), paragraph (15), and an undocumented noncitizen is an individual who resides in

24.1 the United States without the approval or acquiescence of the United States Citizenship  
24.2 and Immigration Services.

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

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

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

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

24.11 Sec. 16. **[256D.031] GENERAL ASSISTANCE MEDICAL CARE.**

24.12 Subdivision 1. Eligibility. (a) Except as provided under subdivision 2, general  
24.13 assistance medical care may be paid for any individual who is not eligible for medical  
24.14 assistance under chapter 256B, including eligibility for medical assistance based on a  
24.15 spenddown of excess income according to section 256B.056, subdivision 5, and who:

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

24.19 (2) is a resident of Minnesota and has gross countable income not in excess of 75  
24.20 percent of federal poverty guidelines for the family size, using a six-month budget period,  
24.21 and whose equity in assets is not in excess of \$1,000 per assistance unit.

24.22 Exempt assets, the reduction of excess assets, and the waiver of excess assets must  
24.23 conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d,  
24.24 except that the maximum amount of undistributed funds in a trust that could be distributed  
24.25 to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's  
24.26 discretion under the terms of the trust, must be applied toward the asset maximum.

24.27 (b) The commissioner shall adjust the income standards under this section each July  
24.28 1 by the annual update of the federal poverty guidelines following publication by the  
24.29 United States Department of Health and Human Services.

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

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

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

25.1 (3) is enrolled in private health coverage as defined in section 256B.02, subdivision  
25.2 9;

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

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

25.7 (6) does not cooperate with the county agency to meet the requirements of medical  
25.8 assistance;

25.9 (7) does not cooperate with a county or state agency or the state medical review team  
25.10 in determining a disability or for determining eligibility for Supplemental Security Income  
25.11 or Social Security Disability Insurance by the Social Security Administration; or

25.12 (8) fails to meet the requirements of section 256L.09, subdivision 2.

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

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

25.22 (d) General assistance medical care recipients who become eligible for medical  
25.23 assistance shall be terminated from general assistance medical care and transferred to  
25.24 medical assistance.

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

25.30 (b) If all other eligibility requirements of this subdivision are met, general assistance  
25.31 medical care may be paid for individuals identified in paragraph (a) for a temporary  
25.32 period beginning the date of application. Eligibility for general assistance medical care  
25.33 shall continue until enrollment in MinnesotaCare is completed. Upon notification of  
25.34 eligibility for MinnesotaCare, notice of termination for eligibility for general assistance  
25.35 medical care shall be sent to the applicant or recipient. Once enrolled in MinnesotaCare,  
25.36 the MinnesotaCare-covered services as described in section 256L.03 shall apply for the

26.1 remainder of the six-month general assistance medical care eligibility period until their  
26.2 six-month renewal.

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

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

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

26.8 (3) is classified as an end-stage renal disease beneficiary in the Medicare program; or

26.9 (4) receives treatment funded in section 254B.02.

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

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

26.15 **Subd. 4. Eligibility and enrollment procedures.** (a) Eligibility for general  
26.16 assistance medical care shall begin no earlier than the date of application. The date of  
26.17 application shall be the date the applicant has provided a name, address, and Social  
26.18 Security number, signed and dated, to the county agency or the Department of Human  
26.19 Services. If the applicant is unable to provide a name, address, Social Security number,  
26.20 and signature when health care is delivered due to a medical condition or disability, a  
26.21 health care provider may act on an applicant's behalf to establish the date of an application  
26.22 by providing the county agency or Department of Human Services with provider  
26.23 identification and a temporary unique identifier for the applicant. The applicant must  
26.24 complete the remainder of the application and provide necessary verification before  
26.25 eligibility can be determined. The applicant must complete the application within the time  
26.26 periods required under the medical assistance program as specified in Minnesota Rules,  
26.27 parts 9505.0015, subpart 5; and 9505.0090, subpart 2. The county agency must assist the  
26.28 applicant in obtaining verification if necessary.

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

26.33 (c) In determining the amount of assets of an individual eligible under subdivision 1,  
26.34 paragraph (a), clause (2), there shall be included any asset or interest in an asset, including  
26.35 an asset excluded under subdivision 1, paragraph (a), that was given away, sold, or  
26.36 disposed of for less than fair market value within the 60 months preceding application for

27.1 general assistance medical care or during the period of eligibility. Any transfer described  
27.2 in this paragraph shall be presumed to have been for the purpose of establishing eligibility  
27.3 for general assistance medical care, unless the individual furnishes convincing evidence to  
27.4 establish that the transaction was exclusively for another purpose. For purposes of this  
27.5 paragraph, the value of the asset or interest shall be the fair market value at the time it  
27.6 was given away, sold, or disposed of, less the amount of compensation received. For any  
27.7 uncompensated transfer, the number of months of ineligibility, including partial months,  
27.8 shall be calculated by dividing the uncompensated transfer amount by the average monthly  
27.9 per person payment made by the medical assistance program to skilled nursing facilities  
27.10 for the previous calendar year. The individual shall remain ineligible until this fixed period  
27.11 has expired. The period of ineligibility may exceed 30 months, and a reapplication for  
27.12 benefits after 30 months from the date of the transfer shall not result in eligibility unless  
27.13 and until the period of ineligibility has expired. The period of ineligibility begins in the  
27.14 month the transfer was reported to the county agency, or if the transfer was not reported,  
27.15 the month in which the county agency discovered the transfer, whichever comes first. For  
27.16 applicants, the period of ineligibility begins on the date of the first approved application.

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

27.22 Subd. 5. **General assistance medical care; services.** (a) General assistance  
27.23 medical care covers:

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

27.25 (2) outpatient hospital services;

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

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

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

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

27.32 (7) hearing aids;

27.33 (8) prosthetic devices;

27.34 (9) laboratory and x-ray services;

27.35 (10) physicians' services;

27.36 (11) medical transportation except special transportation;

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

28.2 (13) podiatric services;

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

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

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

28.7 (17) medical supplies and equipment, and Medicare premiums, coinsurance, and  
28.8 deductible payments;

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

28.12 (19) services performed by a certified pediatric nurse practitioner, a certified family  
28.13 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological  
28.14 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse  
28.15 practitioner in independent practice, if (1) the service is otherwise covered under this  
28.16 chapter as a physician service, (2) the service provided on an inpatient basis is not included  
28.17 as part of the cost for inpatient services included in the operating payment rate, and (3) the  
28.18 service is within the scope of practice of the nurse practitioner's license as a registered  
28.19 nurse, as defined in section 148.171;

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

28.24 (21) telemedicine consultations, to the extent they are covered under section  
28.25 256B.0625, subdivision 3b;

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

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

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

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

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

28.36 (1) \$25 for nonemergency visits to a hospital-based emergency room; and

29.1 (2) \$3 per brand-name drug prescription, subject to a \$7 per month maximum for  
29.2 prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when  
29.3 used for the treatment of mental illness.

29.4 (e) Co-payments shall be limited to one per day per provider for nonemergency  
29.5 visits to a hospital-based emergency room. Recipients of general assistance medical care  
29.6 are responsible for all co-payments in this subdivision. Reimbursement for prescription  
29.7 drugs shall be reduced by the amount of the co-payment until the recipient has reached the  
29.8 \$7 per month maximum for prescription drug co-payments. The provider shall collect  
29.9 the co-payment from the recipient. Providers may not deny services to recipients who  
29.10 are unable to pay the co-payment.

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

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

29.16 **Subd. 6. Temporary division of costs.** (a) Beginning March 1, 2010, and ending  
29.17 July 1, 2011, the county share of state expenditures for general assistance medical care  
29.18 shall be ten percent. The county share of the state expenditures shall be assessed based  
29.19 on the recipient's county of financial responsibility as defined in section 256G.02. To  
29.20 implement this subdivision, the commissioner may select the most appropriate and  
29.21 efficient billing and receipting methods.

29.22 (b) This subdivision is exempt from the limitations described in section 275.77.

29.23 **Subd. 7. Coordinated care delivery option.** (a) A county or group of counties may  
29.24 elect to provide health care and supportive services to individuals who are eligible for  
29.25 general assistance medical care under this section and who reside within the county or  
29.26 counties through a coordinated care delivery option. The health care services provided  
29.27 by the county must include the services described in subdivision 5 with the exception of  
29.28 outpatient prescription drug coverage but including drugs administered in an outpatient  
29.29 setting. Support services may include, but are not limited to, social services, outreach,  
29.30 health care navigation, housing, and transportation. Counties that elect to provide health  
29.31 care services through this option must ensure that the requirements of this subdivision  
29.32 are met. Upon electing to provide services through this option, the county accepts the  
29.33 financial risk of the delivery of the health care services described in this subdivision to  
29.34 general assistance medical care recipients residing in the county for the period beginning  
29.35 July 1, 2010, and ending July 1, 2011, for the fixed payments described in subdivision 10.

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

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

30.5 (2) the geographic area to be served.

30.6 (c) The county may contract with a managed care plan, an integrated delivery  
30.7 system, a physician-hospital organization, or an academic health center to administer  
30.8 the delivery of services through this option. Any county providing general assistance  
30.9 medical care services through a county-based purchasing plan in accordance with section  
30.10 256B.692 may continue to provide services through the county-based purchasing plan.  
30.11 Payments to the county-based purchasing plan for the period beginning July 1, 2010, and  
30.12 ending July 1, 2011, shall be paid according to subdivision 10.

30.13 (d) A county must demonstrate the ability to:

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

30.16 (2) provide a system for advocacy, consumer protection, and complaints and appeals  
30.17 that is independent of care providers or other risk bearers and complies with section  
30.18 256B.69;

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

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

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

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

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

30.29 Subd. 8. **Health care home designation.** The commissioner or a county may  
30.30 require a recipient to designate a primary care provider or a primary care clinic that is  
30.31 certified as a health care home under section 256B.0751.

30.32 Subd. 9. **Payments; fee-for-service rate for the period between March 1,**  
30.33 **2010, and July 1, 2010.** (a) Effective for services provided on or after March 1, 2010,  
30.34 and before July 1, 2010, the payment rates for all covered services provided to general  
30.35 assistance medical care recipients, with the exception of outpatient prescription drug

31.1 coverage, shall be 50 percent of the general assistance medical care payment rate in effect  
31.2 on February 28, 2010.

31.3 (b) Outpatient prescription drug coverage provided on or after March 1, 2010, and  
31.4 before July 1, 2010, shall be paid on a fee-for-service basis in accordance with section  
31.5 256B.0625, subdivision 13e.

31.6 Subd. 10. **Payments; fee-for-service rates for the period between July 1, 2010,**  
31.7 **and July 1, 2011.** (a) Effective for services provided on or after July 1, 2010, and before  
31.8 July 1, 2011, to general assistance medical care recipients residing in counties that are  
31.9 not served through the coordinated care delivery option, payments shall be made by the  
31.10 commissioner to providers at rates described in this subdivision.

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

31.13 (1) 70 percent of the general assistance medical care rate in effect on February  
31.14 28, 2010, if the inpatient hospital services were provided in a hospital where the  
31.15 fee-for-service inpatient and outpatient hospital general assistance medical care payments  
31.16 to the hospital for admissions provided in calendar year 2007 totaled \$1,000,000 or more  
31.17 or the hospital's fee-for-service inpatient and outpatient hospital general assistance medical  
31.18 care payments received for calendar year 2007 admissions was one percent or more of the  
31.19 hospital's net patient revenue received for services provided in calendar year 2007; or

31.20 (2) 40 percent of the general assistance medical care rate in effect on February 28,  
31.21 2010, if the inpatient hospital services were provided by a hospital that does not meet the  
31.22 criteria described in clause (1).

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

31.27 (d) Outpatient prescription drug coverage provided on or after July 1, 2010, and  
31.28 before July 1, 2011, shall be paid on a fee-for-service basis in accordance with section  
31.29 256B.0625, subdivision 13e.

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

31.35 Subd. 11. **Payments; rate setting for the coordinated care delivery option.** (a)  
31.36 Effective for general assistance medical care services, with the exception of outpatient

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32.1 prescription drug coverage, provided on or after July 1, 2010, and before July 1, 2011,  
32.2 to recipients residing in counties that have elected to provide services through the  
32.3 coordinated delivery care option, the commissioner shall establish quarterly prospective  
32.4 fixed payments to the county. The payments must not exceed 60 percent of the county's  
32.5 general assistance medical care county allocation amount as determined in paragraph (b).  
32.6 These payments must not be used by the county to pay MinnesotaCare premiums for  
32.7 general assistance medical care recipients or MinnesotaCare enrollees.

32.8 (b) For each county that elects to provide services in accordance with subdivision  
32.9 7, the commissioner shall determine a general assistance medical care county allocation  
32.10 amount that equals the total general assistance medical care payments made for recipients  
32.11 residing within the county in fiscal year 2009 for all covered general assistance medical  
32.12 care services with the exception of outpatient prescription drug coverage.

32.13 (c) Outpatient prescription drug coverage provided on or after July 1, 2010,  
32.14 and before July 1, 2011, shall be paid on a fee-for-service basis according to section  
32.15 256B.0625, subdivision 13e.

32.16 Subd. 12. **Unallotment.** Appropriations for this program are not subject to section  
32.17 16A.152, subdivision 4.

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

32.20 **Sec. 17. [256D.032] GENERAL ASSISTANCE MEDICAL CARE ACCOUNT.**

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

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

32.24 **Sec. 18. Minnesota Statutes 2008, section 256L.05, subdivision 1b, is amended to read:**

32.25 **Subd. 1b. **MinnesotaCare enrollment by county agencies.**** Beginning September  
32.26 1, 2006, county agencies shall enroll single adults and households with no children  
32.27 formerly enrolled in general assistance medical care in MinnesotaCare according to  
32.28 section 256D.03, subdivision 3, or 256D.031. County agencies shall perform all duties  
32.29 necessary to administer the MinnesotaCare program ongoing for these enrollees, including  
32.30 the redetermination of MinnesotaCare eligibility at renewal.

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

32.32 **Sec. 19. Minnesota Statutes 2008, section 256L.05, subdivision 3, is amended to read:**

33.1           Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the  
33.2 first day of the month following the month in which eligibility is approved and the first  
33.3 premium payment has been received. As provided in section 256B.057, coverage for  
33.4 newborns is automatic from the date of birth and must be coordinated with other health  
33.5 coverage. The effective date of coverage for eligible newly adoptive children added to a  
33.6 family receiving covered health services is the month of placement. The effective date  
33.7 of coverage for other new members added to the family is the first day of the month  
33.8 following the month in which the change is reported. All eligibility criteria must be met  
33.9 by the family at the time the new family member is added. The income of the new family  
33.10 member is included with the family's gross income and the adjusted premium begins in  
33.11 the month the new family member is added.

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

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

33.16           (d) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to  
33.17 256L.18 are secondary to a plan of insurance or benefit program under which an eligible  
33.18 person may have coverage and the commissioner shall use cost avoidance techniques to  
33.19 ensure coordination of any other health coverage for eligible persons. The commissioner  
33.20 shall identify eligible persons who may have coverage or benefits under other plans of  
33.21 insurance or who become eligible for medical assistance.

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

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

33.27           Sec. 20. Minnesota Statutes 2008, section 256L.05, subdivision 3a, is amended to read:

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

33.31           (b) Each new period of eligibility must take into account any changes in  
33.32 circumstances that impact eligibility and premium amount. An enrollee must provide all  
33.33 the information needed to redetermine eligibility by the first day of the month that ends  
33.34 the eligibility period. If there is no change in circumstances, the enrollee may renew  
33.35 eligibility at designated locations that include community clinics and health care providers'

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34.1 offices. The designated sites shall forward the renewal forms to the commissioner. The  
34.2 commissioner may establish criteria and timelines for sites to forward applications to the  
34.3 commissioner or county agencies. The premium for the new period of eligibility must be  
34.4 received as provided in section 256L.06 in order for eligibility to continue.

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

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

34.14 Sec. 21. Minnesota Statutes 2008, section 256L.07, subdivision 6, is amended to read:

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

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

34.20 Sec. 22. Minnesota Statutes 2008, section 256L.15, subdivision 4, is amended to read:

34.21 Subd. 4. **Exception for transitioned adults.** County agencies shall pay premiums  
34.22 for single adults and households with no children formerly enrolled in general assistance  
34.23 medical care and enrolled in MinnesotaCare according to section 256D.03, subdivision 3,  
34.24 or 256D.031, until six-month renewal. The county agency has the option of continuing to  
34.25 pay premiums for these enrollees.

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

34.27 Sec. 23. Minnesota Statutes 2008, section 256L.17, subdivision 7, is amended to read:

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

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

35.1 Sec. 24. **DRUG REBATE PROGRAM.**

35.2 The commissioner of human services shall continue to administer a drug rebate  
35.3 program for drugs purchased for persons eligible for the general assistance medical care  
35.4 program in accordance with Minnesota Statutes, sections 256.01, subdivision 2, paragraph  
35.5 (cc), and 256D.03. The rebate revenues collected under the drug rebate program for  
35.6 persons eligible for the general assistance medical care program shall be deposited in the  
35.7 general assistance medical care account in the special revenue fund established under  
35.8 Minnesota Statutes, section 256D.032.

35.9 **EFFECTIVE DATE.** This section is effective March 1, 2010, and expires June  
35.10 30, 2011.

35.11 Sec. 25. **TEMPORARY SUSPENSION.**

35.12 (a) For the period beginning March 1, 2010, to June 30, 2011, the commissioner  
35.13 of human services shall not implement or administer Minnesota Statutes 2008, section  
35.14 256D.03, subdivisions 6 and 9; Minnesota Statutes 2009 Supplement, section 256D.03,  
35.15 subdivision 4; or Minnesota Statutes 2008, section 256B.692; and Minnesota Statutes  
35.16 2009 Supplement, section 256B.69, as they apply to the general assistance medical care  
35.17 program unless specifically continued in Minnesota Statutes, section 256D.031.

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

35.20 **EFFECTIVE DATE.** This section is effective March 1, 2010, and expires July 1,  
35.21 2011.

35.22 Sec. 26. **MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION**  
35.23 **ASSESSMENT MODIFICATION; TRANSFER.**

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

35.30 Subd. 2. **Transfer.** \$..... shall be transferred in fiscal year 2011 and \$..... in fiscal  
35.31 year 2012 from the general assistance medical care account established in Minnesota  
35.32 Statutes, section 256D.032, to the commissioner of commerce for disbursement upon

36.1 receipt to the Minnesota Comprehensive Health Association, to compensate for the loss in  
36.2 the association's assessments created by the credits specified in subdivision 1.

36.3 Sec. 27. **APPROPRIATION TRANSFERS.**

36.4 (a) Of the general fund appropriation to the commissioner of human services for  
36.5 health care management in Laws 2009, chapter 79, article 13, section 3, subdivision  
36.6 7, as amended by Laws 2009, chapter 173, article 2, section 1, \$3,300,000 for health  
36.7 care administration and \$4,100,000 for health care operations shall be transferred on  
36.8 March 1, 2010, to the fund established in Minnesota Statutes, section 256D.032. These  
36.9 amounts are appropriated to the commissioner for the administration and operation of the  
36.10 general assistance medical care program under Minnesota Statutes, section 256D.031. For  
36.11 purposes of consistent cost allocation and accounting, the commissioner may transfer the  
36.12 amounts appropriated for program administration and operation to the general fund.

36.13 (b) Of the general fund appropriation to the commissioner of human services for  
36.14 general assistance medical care grants in fiscal year 2010 in Laws 2009, chapter 79, article  
36.15 13, section 3, subdivision 6, paragraph (d), as amended by Laws 2009, chapter 173, article  
36.16 2, section 1, \$26,000,000 shall be transferred on March 1, 2010, to the fund established  
36.17 in Minnesota Statutes, section 256D.032.

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

36.19 Sec. 28. **APPROPRIATIONS.**

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

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

36.27 (2) \$..... for the period from March 1, 2010, to June 30, 2010, and \$..... for  
36.28 fiscal year 2011 for the managed care plan rate increase in Minnesota Statutes, section  
36.29 256B.69, subdivision 5k. The commissioner may transfer these appropriations to the  
36.30 medical assistance account in the general fund and pay the rate increases from the medical  
36.31 assistance account; and

36.32 (3) \$..... for the period from March 1, 2010, to June 30, 2010, and \$..... for fiscal  
36.33 year 2011 for the general assistance medical care program established in Minnesota  
36.34 Statutes, section 256D.031.

37.1

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