

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
1.5 2, 3; 256.969, subdivisions 21, 26, 27, by adding subdivisions; 256B.0625,
1.6 subdivision 13f, by adding a subdivision; 256B.69, by adding a subdivision;
1.7 256D.03, subdivisions 3a, 3b; 256D.06, subdivision 7; 256L.05, subdivisions
1.8 1b, 3, 3a; 256L.07, subdivision 6; 256L.15, subdivision 4; 256L.17, subdivision
1.9 7; Minnesota Statutes 2009 Supplement, sections 256.969, subdivisions 2b, 3a,
1.10 30; 256B.195, subdivision 3; 256B.196, subdivision 2; 256B.199; 256D.03,
1.11 subdivision 3; proposing coding for new law in Minnesota Statutes, chapters
1.12 245; 256D.

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

1.14 **ARTICLE 1**

1.15 **HEALTH CARE PROGRAM MODIFICATIONS**

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

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

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

1.25 (a) Mental health urgent care includes:

1.26 (1) initial mental health screening;

1.27 (2) mobile crisis assessment and intervention;

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

2.3 (4) nonhospital crisis stabilization residential beds; and

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

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

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

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

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

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

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

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

2.22 (2) the service shall be provided by a multidisciplinary team including, at a
2.23 minimum, a child and adolescent psychiatrist, an adult psychiatrist, and a licensed clinical
2.24 social worker;

2.25 (3) the service shall include a triage-level assessment to determine the most
2.26 appropriate response to each request, including appropriate referrals to other mental health
2.27 professionals, as well as provision of rapid psychiatric access when other appropriate
2.28 services are not available;

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

2.31 (5) 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 (b) The commissioner shall appoint an interdisciplinary work group to establish
2.34 appropriate medication and psychotherapy protocols to guide the consultative process,
2.35 including consultation with the Drug Utilization Review Board as provided in section
2.36 256B.0625, subdivision 13j.

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

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

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

3.12 Subd. 7. **Flexible implementation.** To implement this section, the commissioner
3.13 shall select the structure and funding method that is the most cost-effective for each county
3.14 or group of counties. This may include grants, contracts, direct provision by state-operated
3.15 services, and public-private partnerships. Where feasible, the commissioner shall make
3.16 any grants under this section a part of the integrated adult mental health initiative grants
3.17 under section 245.4661.

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

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

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

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

3.31 (d) Notwithstanding the Medicare cost finding and allowable cost principles, the
3.32 hospital surcharge is not an allowable cost for purposes of rate setting under sections
3.33 256.9685 to 256.9695.

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

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

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

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

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

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

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

4.25 (3) Medicare revenue, as a result of an arrangement between a health maintenance
4.26 organization or a community integrated service network and the Centers for Medicare
4.27 and Medicaid Services of the federal Department of Health and Human Services, for
4.28 services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited
4.29 from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social
4.30 Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and
4.31 1395w-24, respectively, as they may be amended from time to time; and

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

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

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

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

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

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

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

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

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

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

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

6.21 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
6.22 assistance program must not be submitted until the recipient is discharged. However,
6.23 the commissioner shall establish monthly interim payments for inpatient hospitals that
6.24 have individual patient lengths of stay over 30 days regardless of diagnostic category.
6.25 Except as provided in section 256.9693, medical assistance reimbursement for treatment
6.26 of mental illness shall be reimbursed based on diagnostic classifications. Individual
6.27 hospital payments established under this section and sections 256.9685, 256.9686, and
6.28 256.9695, in addition to third party and recipient liability, for discharges occurring during
6.29 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
6.30 inpatient services paid for the same period of time to the hospital. This payment limitation
6.31 shall be calculated separately for medical assistance and general assistance medical
6.32 care services. The limitation on general assistance medical care shall be effective for
6.33 admissions occurring on or after July 1, 1991. Services that have rates established under
6.34 subdivision 11 or 12, must be limited separately from other services. After consulting with
6.35 the affected hospitals, the commissioner may consider related hospitals one entity and

7.1 may merge the payment rates while maintaining separate provider numbers. The operating
7.2 and property base rates per admission or per day shall be derived from the best Medicare
7.3 and claims data available when rates are established. The commissioner shall determine
7.4 the best Medicare and claims data, taking into consideration variables of recency of the
7.5 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
7.6 The commissioner shall notify hospitals of payment rates by December 1 of the year
7.7 preceding the rate year. The rate setting data must reflect the admissions data used to
7.8 establish relative values. Base year changes from 1981 to the base year established for the
7.9 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
7.10 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
7.11 1. The commissioner may adjust base year cost, relative value, and case mix index data
7.12 to exclude the costs of services that have been discontinued by the October 1 of the year
7.13 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
7.14 that encompass portions of two or more rate years shall have payments established based
7.15 on payment rates in effect at the time of admission unless the date of admission preceded
7.16 the rate year in effect by six months or more. In this case, operating payment rates for
7.17 services rendered during the rate year in effect and established based on the date of
7.18 admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

7.27 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
7.28 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
7.29 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
7.30 from the current statutory rates. Mental health services within diagnosis related groups
7.31 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
7.32 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical
7.33 assistance does not include general assistance medical care. Payments made to managed
7.34 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
7.35 this reduction.

8.1 (e) 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, 2008, through June 30, 2009, made
8.3 to hospitals for inpatient services before third-party liability and spenddown, is reduced
8.4 3.46 percent from the current statutory rates. Mental health services with diagnosis related
8.5 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
8.6 paragraph. Payments made to managed care plans shall be reduced for services provided
8.7 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

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

8.15 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
8.16 for fee-for-service admissions occurring on or after July 1, ~~2010~~ 2011, made to hospitals
8.17 for inpatient services before third-party liability and spenddown, is reduced 1.79 percent
8.18 from the current statutory rates. Mental health services with diagnosis related groups
8.19 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
8.20 Payments made to managed care plans shall be reduced for services provided on or after
8.21 July 1, ~~2010~~ 2011, to reflect this reduction.

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

8.28 (i) In order to offset the ratable reductions provided for in this subdivision, the total
8.29 payment rate for medical assistance fee-for-service admissions occurring on or after
8.30 March 1, 2010, to June 30, 2011, made to Minnesota hospitals for inpatient services
8.31 before third-party liability and spenddown, shall be increased by 14 percent from the
8.32 current statutory rates if the hospital is located in Hennepin or Ramsey County and 18
8.33 percent from the current statutory rates for all other Minnesota hospitals. For purposes
8.34 of this paragraph, medical assistance does not include general assistance medical care.
8.35 This increase shall be paid from the account established in section 256D.032. The
8.36 commissioner shall not adjust rates paid to a prepaid health plan under contract with

9.1 the commissioner to reflect payments provided in this paragraph. The commissioner
9.2 may utilize a settlement process to adjust rates in excess of the Medicare upper limits on
9.3 payments. The commissioner may ratably reduce payments under this paragraph in order
9.4 to comply with section 256B.195, subdivision 3, paragraph (f).

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

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

9.7 Subd. 21. **Mental health or chemical dependency admissions; rates.** (a)

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

9.20 (b) In order to ensure adequate access for the provision of mental health services
9.21 and to encourage broader delivery of these services outside the nonstate governmental
9.22 hospital setting, payment rates for medical assistance admissions occurring on or after
9.23 March 1, 2010, to June 30, 2011, at a Minnesota private, not-for-profit hospital above the
9.24 75th percentile of all Minnesota private, nonprofit hospitals for diagnosis-related groups
9.25 424 to 432 and 521 to 523 admissions paid by medical assistance for admissions occurring
9.26 in calendar year 2007, shall be increased for these diagnosis-related groups at a percentage
9.27 calculated to cost not more than a total of \$40,000,000, including state and federal shares.
9.28 This increase shall be paid from the account established in section 256D.032. For
9.29 purposes of this paragraph, medical assistance does not include general assistance medical
9.30 care. The commissioner shall not adjust rates paid to a prepaid health plan under contract
9.31 with the commissioner to reflect payments provided in this paragraph. The commissioner
9.32 may utilize a settlement process to adjust rates in excess of the Medicare upper limits on
9.33 payments. The commissioner may ratably reduce payments under this paragraph in order
9.34 to comply with section 256B.195, subdivision 3, paragraph (f).

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

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

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

10.7 (1) the hospital's current payment rate for the diagnostic category to which the
10.8 diagnosis-related group belongs, exclusive of disproportionate population adjustments
10.9 received under subdivision 9 and hospital payment adjustments received under subdivision
10.10 23; or

10.11 (2) 90 percent of the average payment rate for that diagnostic category for hospitals
10.12 located within the seven-county metropolitan area, exclusive of disproportionate
10.13 population adjustments received under subdivision 9 and hospital payment adjustments
10.14 received under subdivisions 20 and 23.

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

- 10.17 (1) 370 cesarean section with complicating diagnosis;
10.18 (2) 371 cesarean section without complicating diagnosis;
10.19 (3) 372 vaginal delivery with complicating diagnosis;
10.20 (4) 373 vaginal delivery without complicating diagnosis;
10.21 (5) 386 extreme immaturity and respiratory distress syndrome, neonate;
10.22 (6) 388 full-term neonates with other problems;
10.23 (7) 390 prematurity without major problems;
10.24 (8) 391 normal newborn;
10.25 (9) 385 neonate, died or transferred to another acute care facility;
10.26 (10) 425 acute adjustment reaction and psychosocial dysfunction;
10.27 (11) 430 psychoses;
10.28 (12) 431 childhood mental disorders; and
10.29 (13) 164-167 appendectomy.

10.30 For medical assistance admissions occurring on or after March 1, 2010, to June 30,
10.31 2011, the payment rate under paragraph (a), clause (2), shall be increased to 100 percent
10.32 from 90 percent, after application of the rate increase in subdivision 3a, paragraph (i). This
10.33 increase shall be paid from the account established in section 256D.032. For purposes
10.34 of this paragraph, medical assistance does not include general assistance medical care.
10.35 The commissioner shall not adjust rates paid to a prepaid health plan under contract with

11.1 the commissioner to reflect payments provided in this paragraph. The commissioner
11.2 may utilize a settlement process to adjust rates in excess of the Medicare upper limits on
11.3 payments. The commissioner may ratably reduce payments under this paragraph in order
11.4 to comply with section 256B.195, subdivision 3, paragraph (f).

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

11.6 Sec. 8. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision
11.7 to read:

11.8 Subd. 26a. **Psychiatric and burn services payment adjustment on or after July**
11.9 **1, 2010.** (a) For admissions occurring on or after July 1, 2010, the commissioner shall
11.10 increase the total payment for medical assistance fee-for-service inpatient admissions for
11.11 the diagnosis-related groups specified in paragraph (b) at any hospital that is a nonstate
11.12 public Minnesota hospital and a Level I trauma center. The rate increases shall be
11.13 established for each hospital by the commissioner at a level that uses each hospital's
11.14 voluntary payments under paragraph (c) as the nonfederal share. For purposes of
11.15 this subdivision, medical assistance does not include general assistance medical care.
11.16 Payments to managed care health plans shall not be increased for payments under this
11.17 subdivision.

11.18 (b) The rate increases provided in paragraph (a) apply to the following
11.19 diagnosis-related groups or subgroups, or any subsequent designations of such groups
11.20 or subgroups: 424 to 431, 433, 504 to 511, 521, and 523. These increases are only
11.21 available to the extent that revenue is available from the counties under paragraph (c)
11.22 for the nonfederal share.

11.23 (c) Effective July 15, 2010, in addition to any payment otherwise required under
11.24 sections 256B.19, 256B.195, 256B.196, and 256B.199, the following government entities
11.25 may make the following voluntary payments to the commissioner on an annual basis:

11.26 (1) Hennepin County, \$7,000,000; and

11.27 (2) Ramsey County, \$3,500,000.

11.28 The amounts in this paragraph shall be part of the designated governmental unit's portion of
11.29 the nonfederal share of medical assistance costs, including payments under subdivision 9.

11.30 (d) The commissioner may adjust the intergovernmental transfers under paragraph
11.31 (c) and the payments under paragraph (a) based on the commissioner's determination of
11.32 Medicare upper payment limits, hospital-specific charge limits, and any limits imposed
11.33 by the federal government regarding the rate increase or the restriction in the American
11.34 Resource and Recovery Act regarding increased local share.

12.1 (e) This section shall be implemented upon federal approval, retroactive to July 1,
12.2 2010, for services provided on or after that date.

12.3 Sec. 9. Minnesota Statutes 2008, section 256.969, subdivision 27, is amended to read:

12.4 Subd. 27. **Quarterly payment adjustment.** (a) In addition to any other payment
12.5 under this section, the commissioner shall make the following payments effective July
12.6 1, 2007:

12.7 (1) for a hospital located in Minnesota and not eligible for payments under
12.8 subdivision 20, with a medical assistance inpatient utilization rate greater than 17.8
12.9 percent of total patient days as of the base year in effect on July 1, 2005, a payment
12.10 equal to 13 percent of the total of the operating and property payment rates, except that
12.11 Hennepin County Medical Center and Regions Hospital shall not receive a payment
12.12 under this subdivision;

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

12.21 (3) for a hospital located in Minnesota but not located in a specified urban area
12.22 under clause (2), with a medical assistance inpatient utilization rate less than or equal to
12.23 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment
12.24 equal to four percent of the total of the operating and property payment rates. A hospital
12.25 located in Woodbury and not in existence during the base year shall be reimbursed under
12.26 this clause; and

12.27 (4) in addition to any payments under clauses (1) to (3), for a hospital located in
12.28 Minnesota and not eligible for payments under subdivision 20 with a medical assistance
12.29 inpatient utilization rate of 17.9 percent of total patient days as of the base year in effect
12.30 on July 1, 2005, a payment equal to eight percent of the total of the operating and property
12.31 payment rates, and for a hospital located in Minnesota and not eligible for payments
12.32 under subdivision 20 with a medical assistance inpatient utilization rate of 59.6 percent
12.33 of total patient days as of the base year in effect on July 1, 2005, a payment equal to
12.34 nine percent of the total of the operating and property payment rates. After making any
12.35 ratable adjustments required under paragraph (b), the commissioner shall proportionately

13.1 reduce payments under clauses (2) and (3) by an amount needed to make payments under
13.2 this clause.

13.3 (b) The state share of payments under paragraph (a) shall be equal to federal
13.4 reimbursements to the commissioner to reimburse expenditures reported under section
13.5 256B.199, paragraphs (a) to (d). The commissioner shall ratably reduce or increase
13.6 payments under this subdivision in order to ensure that these payments equal the amount
13.7 of reimbursement received by the commissioner under section 256B.199, paragraphs (a)
13.8 to (d), except that payments shall be ratably reduced by an amount equivalent to the state
13.9 share of a four percent reduction in MinnesotaCare and medical assistance payments for
13.10 inpatient hospital services. Effective July 1, 2009, the ratable reduction shall be equivalent
13.11 to the state share of a three percent reduction in these payments. Effective for federal
13.12 disproportionate share hospital funds earned on general assistance medical care payments
13.13 for services rendered on or after March 1, 2010, to June 30, 2011, the amount of the three
13.14 percent ratable reduction required under this paragraph shall be deposited in the account
13.15 established in section 256D.032.

13.16 (c) The payments under paragraph (a) shall be paid quarterly based on each hospital's
13.17 operating and property payments from the second previous quarter, beginning on July
13.18 15, 2007, or upon federal approval of federal reimbursements under section 256B.199,
13.19 paragraphs (a) to (d), whichever occurs later.

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

13.22 (e) The commissioner shall maximize the use of available federal money for
13.23 disproportionate share hospital payments and shall maximize payments to qualifying
13.24 hospitals. In order to accomplish these purposes, the commissioner may, in consultation
13.25 with the nonstate entities identified in section 256B.199, paragraphs (a) to (d), adjust,
13.26 on a pro rata basis if feasible, the amounts reported by nonstate entities under section
13.27 256B.199, paragraphs (a) to (d), when application for reimbursement is made to the federal
13.28 government, and otherwise adjust the provisions of this subdivision. The commissioner
13.29 shall utilize a settlement process based on finalized data to maximize revenue under
13.30 section 256B.199, paragraphs (a) to (d), and payments under this section.

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

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

14.1 Sec. 10. Minnesota Statutes 2009 Supplement, section 256.969, subdivision 30,
14.2 is amended to read:

14.3 Subd. 30. **Payment rates for births.** (a) For admissions occurring on or after
14.4 October 1, 2009, the total operating and property payment rate, excluding disproportionate
14.5 population adjustment, for the following diagnosis-related groups, as they fall within
14.6 the diagnostic categories: (1) 371 cesarean section without complicating diagnosis; (2)
14.7 372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without
14.8 complicating diagnosis, shall be no greater than \$3,528.

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

14.10 (c) Payments to managed care and county-based purchasing plans under section
14.11 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October
14.12 1, 2009, to reflect the adjustments in paragraph (a).

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

14.15 (e) In order to ensure adequate access for the provision of maternity services and
14.16 to encourage broader delivery of these services outside the nonstate governmental
14.17 hospital setting, and notwithstanding paragraph (a), payment rates for medical assistance
14.18 admissions occurring from March 1, 2010, to June 30, 2011, at a private, not-for-profit
14.19 hospital above the 65th percentile of all Minnesota private, nonprofit hospitals for
14.20 diagnosis-related groups 370 to 373 and 391 admissions paid by medical assistance for
14.21 admissions provided in calendar year 2007, shall be increased for these diagnosis-related
14.22 groups at a percentage calculated to cost not more than a total of \$35,000,000, including
14.23 state and federal shares. This increase shall be paid from the account established in section
14.24 256D.032. For purposes of this paragraph, medical assistance does not include general
14.25 assistance medical care. The commissioner shall not adjust rates paid to a prepaid health
14.26 plan under contract with the commissioner to reflect payments provided in this paragraph.
14.27 The commissioner may utilize a settlement process to adjust rates in excess of the Medicare
14.28 upper limits on payments. The commissioner may ratably reduce payments under this
14.29 paragraph in order to comply with section 256B.195, subdivision 3, paragraph (f).

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

14.31 Sec. 11. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision
14.32 to read:

14.33 Subd. 31. **Rate increase for hospitals in cities of the third class and fourth class.**
14.34 Effective for services rendered on or after March 1, 2010, to June 30, 2011, payment rates
14.35 for medical assistance admissions, excluding general assistance medical care admissions,

15.1 at Minnesota hospitals with fewer than 500 medical assistance admissions during fiscal
15.2 year 2008 and located in cities of the third class or of the fourth class, as defined in
15.3 section 410.01, shall be increased by 27 percent. This increase shall be paid from the
15.4 account established in section 256D.032. The commissioner shall not adjust rates paid to a
15.5 prepaid health plan under contract with the commissioner to reflect payments provided
15.6 in this paragraph. The commissioner may utilize a settlement process to adjust rates in
15.7 excess of the Medicare upper limits on payments. The commissioner may ratably reduce
15.8 payments under this paragraph in order to comply with section 256B.195, subdivision 3,
15.9 paragraph (f).

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

15.11 Sec. 12. Minnesota Statutes 2008, section 256B.0625, subdivision 13f, is amended to
15.12 read:

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

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

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

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

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

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

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

- 16.1 (1) there is no generically equivalent drug available; and
16.2 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or
16.3 (3) the drug is part of the recipient's current course of treatment.

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

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

16.15 (e) The commissioner may require prior authorization for brand name drugs
16.16 whenever a generically equivalent product is available, even if the prescriber specifically
16.17 indicates "dispense as written-brand necessary" on the prescription as required by section
16.18 151.21, subdivision 2.

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

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

16.29 Sec. 13. Minnesota Statutes 2008, section 256B.0625, is amended by adding a
16.30 subdivision to read:

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

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

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

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

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

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

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

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

17.24 (c) For purposes of this subdivision, a collaborative psychiatric consultation must
17.25 meet the criteria described in section 245.4862, subdivision 4.

17.26 Sec. 14. Minnesota Statutes 2009 Supplement, section 256B.195, subdivision 3,
17.27 is amended to read:

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

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

17.34 (2) to Regions Hospital, any federal matching funds available to match the payments
17.35 received by the hospital under subdivision 2, to increase payments for medical assistance

18.1 admissions and to recognize higher medical assistance costs in institutions that provide
18.2 high levels of charity care.

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

18.6 (1) 18 percent, plus any federal matching funds, shall be allocated for the following
18.7 purposes:

18.8 (i) during the fiscal year beginning July 1, 2001, of the amount available under
18.9 this clause, 39.7 percent shall be allocated to make increased hospital payments under
18.10 section 256.969, subdivision 26; 34.2 percent shall be allocated to fund the amounts
18.11 due from small rural hospitals, as defined in section 144.148, for overpayments under
18.12 section 256.969, subdivision 5a, resulting from a determination that medical assistance
18.13 and general assistance payments exceeded the charge limit during the period from 1994 to
18.14 1997; and 26.1 percent shall be allocated to the commissioner of health for rural hospital
18.15 capital improvement grants under section 144.148; and

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

18.20 (2) 11 percent shall be allocated to the commissioner of health to fund community
18.21 clinic grants under section 145.9268.

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

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

18.33 (e) Effective July 1, 2003, if the amount available for allocation under paragraph
18.34 (b) is greater than the amounts available during March 2003, after any increase in
18.35 intergovernmental transfers and payments that result from section 256.969, subdivision
18.36 3a, paragraph (c), are paid to the general fund, any additional amounts available under this

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19.1 subdivision after reimbursement of the transfers under subdivision 2 shall be allocated to
19.2 increase medical assistance payments, subject to hospital-specific charge limits and limits
19.3 on disproportionate share hospital payments, as follows:

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

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

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

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

19.21 Sec. 15. Minnesota Statutes 2009 Supplement, section 256B.196, subdivision 2,
19.22 is amended to read:

19.23 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and
19.24 subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital
19.25 services upper payment limit for nonstate government hospitals. The commissioner shall
19.26 then determine the amount of a supplemental payment to Hennepin County Medical
19.27 Center and Regions Hospital for these services that would increase medical assistance
19.28 spending in this category to the aggregate upper payment limit for all nonstate government
19.29 hospitals in Minnesota. In making this determination, the commissioner shall allot the
19.30 available increases between Hennepin County Medical Center and Regions Hospital
19.31 based on the ratio of medical assistance fee-for-service outpatient hospital payments to
19.32 the two facilities. The commissioner shall adjust this allotment as necessary based on
19.33 federal approvals, the amount of intergovernmental transfers received from Hennepin and
19.34 Ramsey Counties, and other factors, in order to maximize the additional total payments.
19.35 The commissioner shall inform Hennepin County and Ramsey County of the periodic

20.1 intergovernmental transfers necessary to match federal Medicaid payments available
20.2 under this subdivision in order to make supplementary medical assistance payments to
20.3 Hennepin County Medical Center and Regions Hospital equal to an amount that when
20.4 combined with existing medical assistance payments to nonstate governmental hospitals
20.5 would increase total payments to hospitals in this category for outpatient services to
20.6 the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon
20.7 receipt of these periodic transfers, the commissioner shall make supplementary payments
20.8 to Hennepin County Medical Center and Regions Hospital.

20.9 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall
20.10 determine an upper payment limit for physicians affiliated with Hennepin County Medical
20.11 Center and with Regions Hospital. The upper payment limit shall be based on the average
20.12 commercial rate or be determined using another method acceptable to the Centers for
20.13 Medicare and Medicaid Services. The commissioner shall inform Hennepin County and
20.14 Ramsey County of the periodic intergovernmental transfers necessary to match the federal
20.15 Medicaid payments available under this subdivision in order to make supplementary
20.16 payments to physicians affiliated with Hennepin County Medical Center and Regions
20.17 Hospital equal to the difference between the established medical assistance payment for
20.18 physician services and the upper payment limit. Upon receipt of these periodic transfers,
20.19 the commissioner shall make supplementary payments to physicians of Hennepin Faculty
20.20 Associates and HealthPartners.

20.21 (c) Beginning January 1, 2010, Hennepin County and Ramsey County ~~shall~~ may
20.22 make monthly voluntary intergovernmental transfers to the commissioner in ~~the following~~
20.23 amounts: ~~\$133,333~~ by not to exceed \$12,000,000 per year from Hennepin County
20.24 ~~and \$100,000~~ by \$6,000,000 per year from Ramsey County. The commissioner shall
20.25 increase the medical assistance capitation payments to ~~Metropolitan Health Plan and~~
20.26 ~~HealthPartners~~ by any licensed health plan under contract with the medical assistance
20.27 program that makes payments to Hennepin County Medical Center or Regions Hospital.
20.28 The increase shall be in an amount equal to the annual value of the monthly transfers
20.29 plus federal financial participation, with each health plan receiving its pro rata share
20.30 of the increase based on the pro rata share of admissions to Hennepin County Medical
20.31 Center and Regions Hospital by those plans. Upon the request of the commissioner,
20.32 health plans shall submit individual-level cost data for verification purposes. The
20.33 commissioner may ratably reduce these payments on a pro rata basis in order to satisfy
20.34 federal requirements for actuarial soundness. If payments are reduced, transfers shall be
20.35 reduced accordingly. Any licensed health plan that receives increased medical assistance
20.36 capitation payments under the intergovernmental transfer described in this paragraph shall

21.1 increase its Minnesota health care program payments to Hennepin County Medical Center
21.2 and Regions Hospital by the same amount as the increased payments received in the
21.3 capitation payment described in this paragraph.

21.4 (d) The commissioner shall inform Hennepin County and Ramsey County on an
21.5 ongoing basis of the need for any changes needed in the intergovernmental transfers
21.6 in order to continue the payments under paragraphs (a) to (c), at their maximum level,
21.7 including increases in upper payment limits, changes in the federal Medicaid match, and
21.8 other factors.

21.9 (e) The payments in paragraphs (a) to (c) shall be implemented independently of
21.10 each other, subject to federal approval and to the receipt of transfers under subdivision 3.

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

21.12 Sec. 16. Minnesota Statutes 2009 Supplement, section 256B.199, is amended to read:

21.13 **256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.**

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

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

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

21.22 (2) based on these reports, the commissioner shall apply for federal matching
21.23 funds. These funds are appropriated to the commissioner for the payments under section
21.24 256.969, subdivision 27; and

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

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

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

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

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

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

22.9 (d) For the period from April 1, 2009, to September 30, 2010, the commissioner shall
22.10 apply for additional federal matching funds available as disproportionate share hospital
22.11 payments under the American Recovery and Reinvestment Act of 2009. These funds shall
22.12 be made available as the state share of payments under section 256.969, subdivision 28.
22.13 The entities required to report certified public expenditures under paragraph (b), clause
22.14 (1), shall report additional certified public expenditures as necessary under this paragraph.

22.15 (e) Effective July 15, 2010, in addition to any payment otherwise required under
22.16 sections 256B.19, 256B.195, and 256B.196, the following government entities may make
22.17 the following voluntary payments to the commissioner on an annual basis:

22.18 (1) Hennepin County, \$6,200,000; and

22.19 (2) Ramsey County, \$4,000,000.

22.20 (f) The sums in paragraph (e) shall be part of the designated governmental unit's
22.21 portion of the nonfederal share of medical assistance costs.

22.22 (g) Effective July 15, 2010, the commissioner shall make the following Medicaid
22.23 disproportionate share hospital payments to the hospitals on a monthly basis:

22.24 (1) to Hennepin County Medical Center, the amount of the transfer under paragraph
22.25 (e), clause (1), plus any federal matching funds available to recognize higher medical
22.26 assistance costs in institutions that provide high levels of charity care; and

22.27 (2) to Regions Hospital, the amount of the transfer under paragraph (e), clause (2),
22.28 plus any federal matching funds available to recognize higher medical assistance costs in
22.29 institutions that provide high levels of charity care.

22.30 (h) Effective July 15, 2010, after making the payments provided in paragraph
22.31 (g), the commissioner shall make the increased payments provided in section 256.969,
22.32 subdivision 26a.

22.33 (i) The commissioner shall make the payments under paragraphs (g) and (h) prior
22.34 to making any other payments under this section, section 256.969, subdivision 27, or
22.35 256B.195.

23.1 (j) The commissioner may adjust the intergovernmental transfers under paragraph
23.2 (e) and the payments under paragraph (g) based on the commissioner's determination
23.3 of Medicare upper payment limits, hospital-specific charge limits, and any limitations
23.4 imposed by the federal government regarding the rate increase or the restriction in the
23.5 American Resource and Recovery Act regarding increased local share.

23.6 (k) This section shall be implemented upon federal approval of the rate increase and
23.7 a federal determination that the increased transfers do not violate the restriction in the
23.8 American Resource and Recovery Act regarding the local share, retroactive to admissions
23.9 occurring on or after July 15, 2010.

23.10 Sec. 17. Minnesota Statutes 2008, section 256B.69, is amended by adding a
23.11 subdivision to read:

23.12 Subd. 5k. **Temporary rate modifications.** For services rendered effective May
23.13 1, 2010, to June 30, 2011, the total payment made to managed care plans under the
23.14 medical assistance program and under MinnesotaCare for families with children shall be
23.15 increased by 4.61 percent. This increase shall be paid from the account established in
23.16 section 256D.032.

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

23.18 Sec. 18. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, is
23.19 amended to read:

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

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

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

23.29 (i) who has gross countable income not in excess of 75 percent of the federal poverty
23.30 guidelines for the family size, using a six-month budget period and whose equity in assets
23.31 is not in excess of \$1,000 per assistance unit. General assistance medical care is not
23.32 available for applicants or enrollees who are otherwise eligible for medical assistance but
23.33 fail to verify their assets. Enrollees who become eligible for medical assistance shall be
23.34 terminated and transferred to medical assistance. Exempt assets, the reduction of excess

24.1 assets, and the waiver of excess assets must conform to the medical assistance program in
24.2 section 256B.056, subdivisions 3 and 3d, with the following exception: the maximum
24.3 amount of undistributed funds in a trust that could be distributed to or on behalf of the
24.4 beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the
24.5 terms of the trust, must be applied toward the asset maximum; or

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

24.10 (b) The commissioner shall adjust the income standards under this section each July
24.11 1 by the annual update of the federal poverty guidelines following publication by the
24.12 United States Department of Health and Human Services.

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

24.17 (d) Effective for applications and renewals processed on or after September 1,
24.18 2006, general assistance medical care may be paid for applicants and recipients who
24.19 meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary
24.20 period beginning the date of application. Immediately following approval of general
24.21 assistance medical care, enrollees shall be enrolled in MinnesotaCare under section
24.22 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest
24.23 of the six-month general assistance medical care eligibility period, until their six-month
24.24 renewal. This paragraph does not apply to applicants and recipients who are exempt
24.25 under paragraph (f).

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

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

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

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

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

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

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

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

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

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

25.6 If an enrollee meets one of the categories described in this paragraph, the commissioner
25.7 shall not require the enrollee to enroll in MinnesotaCare.

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

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

25.23 (i) The date of an initial Minnesota health care program application necessary to
25.24 begin a determination of eligibility shall be the date the applicant has provided a name,
25.25 address, and Social Security number, signed and dated, to the county agency or the
25.26 Department of Human Services. If the applicant is unable to provide a name, address,
25.27 Social Security number, and signature when health care is delivered due to a medical
25.28 condition or disability, a health care provider may act on an applicant's behalf to establish
25.29 the date of an initial Minnesota health care program application by providing the county
25.30 agency or Department of Human Services with provider identification and a temporary
25.31 unique identifier for the applicant. The applicant must complete the remainder of the
25.32 application and provide necessary verification before eligibility can be determined. The
25.33 applicant must complete the application within the time periods required under the
25.34 medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart
25.35 5, and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining
25.36 verification if necessary.

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

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

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

26.14 (m) In determining the amount of assets of an individual eligible under paragraph
26.15 (a), clause (2), item (i), there shall be included any asset or interest in an asset, including
26.16 an asset excluded under paragraph (a), that was given away, sold, or disposed of for
26.17 less than fair market value within the 60 months preceding application for general
26.18 assistance medical care or during the period of eligibility. Any transfer described in this
26.19 paragraph shall be presumed to have been for the purpose of establishing eligibility for
26.20 general assistance medical care, unless the individual furnishes convincing evidence to
26.21 establish that the transaction was exclusively for another purpose. For purposes of this
26.22 paragraph, the value of the asset or interest shall be the fair market value at the time it
26.23 was given away, sold, or disposed of, less the amount of compensation received. For any
26.24 uncompensated transfer, the number of months of ineligibility, including partial months,
26.25 shall be calculated by dividing the uncompensated transfer amount by the average monthly
26.26 per person payment made by the medical assistance program to skilled nursing facilities
26.27 for the previous calendar year. The individual shall remain ineligible until this fixed period
26.28 has expired. The period of ineligibility may exceed 30 months, and a reapplication for
26.29 benefits after 30 months from the date of the transfer shall not result in eligibility unless
26.30 and until the period of ineligibility has expired. The period of ineligibility begins in the
26.31 month the transfer was reported to the county agency, or if the transfer was not reported,
26.32 the month in which the county agency discovered the transfer, whichever comes first. For
26.33 applicants, the period of ineligibility begins on the date of the first approved application.

26.34 (n) When determining eligibility for any state benefits under this subdivision,
26.35 the income and resources of all noncitizens shall be deemed to include their sponsor's
26.36 income and resources as defined in the Personal Responsibility and Work Opportunity

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27.1 Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and
27.2 subsequently set out in federal rules.

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

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

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

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

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

27.17 Sec. 19. Minnesota Statutes 2008, section 256D.03, subdivision 3a, is amended to read:

27.18 Subd. 3a. **Claims; assignment of benefits.** (a) Claims must be filed pursuant to
27.19 section 256D.16. General assistance medical care applicants and recipients must apply or
27.20 agree to apply third party health and accident benefits to the costs of medical care. They
27.21 must cooperate with the state in establishing paternity and obtaining third party payments.
27.22 By accepting general assistance, a person assigns to the Department of Human Services
27.23 all rights to medical support or payments for medical expenses from another person or
27.24 entity on their own or their dependent's behalf and agrees to cooperate with the state in
27.25 establishing paternity and obtaining third party payments. The application shall contain
27.26 a statement explaining the assignment. Any rights or amounts assigned shall be applied
27.27 against the cost of medical care paid for under this chapter. An assignment is effective on
27.28 the date general assistance medical care eligibility takes effect.

27.29 (b) Effective for general assistance medical care services rendered on or after
27.30 March 1, 2010, to June 30, 2011, any medical collections, payments, or recoveries under
27.31 this subdivision shall be deposited in or credited to the account established in section
27.32 256D.032.

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

28.1 Sec. 20. Minnesota Statutes 2008, section 256D.03, subdivision 3b, is amended to read:

28.2 Subd. 3b. **Cooperation.** (a) General assistance or general assistance medical care
28.3 applicants and recipients must cooperate with the state and local agency to identify
28.4 potentially liable third-party payors and assist the state in obtaining third-party payments.
28.5 Cooperation includes identifying any third party who may be liable for care and services
28.6 provided under this chapter to the applicant, recipient, or any other family member for
28.7 whom application is made and providing relevant information to assist the state in pursuing
28.8 a potentially liable third party. General assistance medical care applicants and recipients
28.9 must cooperate by providing information about any group health plan in which they may
28.10 be eligible to enroll. They must cooperate with the state and local agency in determining
28.11 if the plan is cost-effective. For purposes of this subdivision, coverage provided by the
28.12 Minnesota Comprehensive Health Association under chapter 62E shall not be considered
28.13 group health plan coverage or cost-effective by the state and local agency. If the plan is
28.14 determined cost-effective and the premium will be paid by the state or local agency or is
28.15 available at no cost to the person, they must enroll or remain enrolled in the group health
28.16 plan. Cost-effective insurance premiums approved for payment by the state agency and
28.17 paid by the local agency are eligible for reimbursement according to subdivision 6.

28.18 (b) Effective for all premiums due on or after June 30, 1997, general assistance
28.19 medical care does not cover premiums that a recipient is required to pay under a qualified
28.20 or Medicare supplement plan issued by the Minnesota Comprehensive Health Association.
28.21 General assistance medical care shall continue to cover premiums for recipients who are
28.22 covered under a plan issued by the Minnesota Comprehensive Health Association on June
28.23 30, 1997, for a period of six months following receipt of the notice of termination or
28.24 until December 31, 1997, whichever is later.

28.25 (c) Effective for general assistance medical care services rendered on or after
28.26 March 1, 2010, to June 30, 2011, any medical collections, payments, or recoveries under
28.27 this subdivision shall be deposited in or credited to the account established in section
28.28 256D.032.

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

28.30 Sec. 21. **[256D.031] GENERAL ASSISTANCE MEDICAL CARE.**

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

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

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

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

29.12 (b) The commissioner shall adjust the income standards under this section each July
29.13 1 by the annual update of the federal poverty guidelines following publication by the
29.14 United States Department of Health and Human Services.

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

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

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

29.19 (3) is enrolled in private health coverage as defined in section 256B.02, subdivision
29.20 9;

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

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

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

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

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

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

30.4 (d) General assistance medical care recipients who become eligible for medical
30.5 assistance shall be terminated from general assistance medical care and transferred to
30.6 medical assistance.

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

30.12 (b) If all other eligibility requirements of this subdivision are met, general assistance
30.13 medical care may be paid for individuals identified in paragraph (a) for a temporary
30.14 period beginning the date of application. Eligibility for general assistance medical care
30.15 shall continue until enrollment in MinnesotaCare is completed. Upon notification of
30.16 eligibility for MinnesotaCare, notice of termination for eligibility for general assistance
30.17 medical care shall be sent to the applicant or recipient. Once enrolled in MinnesotaCare,
30.18 the MinnesotaCare-covered services as described in section 256L.03 shall apply for the
30.19 remainder of the six-month general assistance medical care eligibility period until their
30.20 six-month renewal.

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

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

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

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

30.27 (4) receives treatment funded in section 254B.02; or

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

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

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

30.34 Subd. 4. **Eligibility and enrollment procedures.** (a) Eligibility for general
30.35 assistance medical care shall begin no earlier than the date of application. The date of
30.36 application shall be the date the applicant has provided a name, address, and Social

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31.1 Security number, signed and dated, to the county agency or the Department of Human
31.2 Services. If the applicant is unable to provide a name, address, Social Security number,
31.3 and signature when health care is delivered due to a medical condition or disability, a
31.4 health care provider may act on an applicant's behalf to establish the date of an application
31.5 by providing the county agency or Department of Human Services with provider
31.6 identification and a temporary unique identifier for the applicant. The applicant must
31.7 complete the remainder of the application and provide necessary verification before
31.8 eligibility can be determined. The applicant must complete the application within the time
31.9 periods required under the medical assistance program as specified in Minnesota Rules,
31.10 parts 9505.0015, subpart 5; and 9505.0090, subpart 2. The county agency must assist the
31.11 applicant in obtaining verification if necessary.

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

31.16 (c) In determining the amount of assets of an individual eligible under subdivision 1,
31.17 paragraph (a), clause (2), there shall be included any asset or interest in an asset, including
31.18 an asset excluded under subdivision 1, paragraph (a), that was given away, sold, or
31.19 disposed of for less than fair market value within the 60 months preceding application for
31.20 general assistance medical care or during the period of eligibility. Any transfer described
31.21 in this paragraph shall be presumed to have been for the purpose of establishing eligibility
31.22 for general assistance medical care, unless the individual furnishes convincing evidence to
31.23 establish that the transaction was exclusively for another purpose. For purposes of this
31.24 paragraph, the value of the asset or interest shall be the fair market value at the time it
31.25 was given away, sold, or disposed of, less the amount of compensation received. For any
31.26 uncompensated transfer, the number of months of ineligibility, including partial months,
31.27 shall be calculated by dividing the uncompensated transfer amount by the average monthly
31.28 per person payment made by the medical assistance program to skilled nursing facilities
31.29 for the previous calendar year. The individual shall remain ineligible until this fixed period
31.30 has expired. The period of ineligibility may exceed 30 months, and a reapplication for
31.31 benefits after 30 months from the date of the transfer shall not result in eligibility unless
31.32 and until the period of ineligibility has expired. The period of ineligibility begins in the
31.33 month the transfer was reported to the county agency, or if the transfer was not reported,
31.34 the month in which the county agency discovered the transfer, whichever comes first. For
31.35 applicants, the period of ineligibility begins on the date of the first approved application.

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

32.6 Subd. 5. General assistance medical care; services. (a) General assistance
32.7 medical care covers:

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

32.9 (2) outpatient hospital services;

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

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

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

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

32.16 (7) hearing aids;

32.17 (8) prosthetic devices;

32.18 (9) laboratory and x-ray services;

32.19 (10) physicians' services;

32.20 (11) medical transportation except special transportation;

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

32.22 (13) podiatric services;

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

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

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

32.27 (17) medical supplies and equipment, and Medicare premiums, coinsurance, and
32.28 deductible payments;

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

32.32 (19) services performed by a certified pediatric nurse practitioner, a certified family
32.33 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological
32.34 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse
32.35 practitioner in independent practice, if: (i) the service is otherwise covered under this
32.36 chapter as a physician service, (ii) the service provided on an inpatient basis is not

33.1 included as part of the cost for inpatient services included in the operating payment rate,
33.2 and (iii) the service is within the scope of practice of the nurse practitioner's license as a
33.3 registered nurse, as defined in section 148.171;

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

33.8 (21) telemedicine consultations, to the extent they are covered under section
33.9 256B.0625, subdivision 3b;

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

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

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

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

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

33.20 (1) \$25 for nonemergency visits to a hospital-based emergency room; and

33.21 (2) \$3 per brand-name drug prescription, subject to a \$7 per month maximum for
33.22 prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when
33.23 used for the treatment of mental illness.

33.24 (e) Co-payments shall be limited to one per day per provider for nonemergency
33.25 visits to a hospital-based emergency room. Recipients of general assistance medical care
33.26 are responsible for all co-payments in this subdivision. Reimbursement for prescription
33.27 drugs shall be reduced by the amount of the co-payment until the recipient has reached the
33.28 \$7 per month maximum for prescription drug co-payments. The provider shall collect
33.29 the co-payment from the recipient. Providers may not deny services to recipients who
33.30 are unable to pay the co-payment.

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

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

34.1 Subd. 6. Coordinated care delivery option. (a) A county or group of counties may
34.2 elect to provide health care services to individuals who are eligible for general assistance
34.3 medical care under this section and who reside within the county or counties through
34.4 a coordinated care delivery option. The health care services provided by the county
34.5 must include the services described in subdivision 5 with the exception of outpatient
34.6 prescription drug coverage but including drugs administered in an outpatient setting.
34.7 Counties that elect to provide health care services through this option must ensure that
34.8 the requirements of this subdivision are met. Upon electing to provide services through
34.9 this option, the county accepts the financial risk of the delivery of the health care services
34.10 described in this subdivision to general assistance medical care recipients residing in
34.11 the county for the period beginning July 1, 2010, and ending July 1, 2011, for the fixed
34.12 payments described in subdivision 10.

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

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

34.17 (2) the geographic area to be served.

34.18 (c) The county may contract with a managed care plan, an integrated delivery
34.19 system, a physician-hospital organization, or an academic health center to administer
34.20 the delivery of services through this option. Any county providing general assistance
34.21 medical care services through a county-based purchasing plan in accordance with section
34.22 256B.692 may continue to provide services through the county-based purchasing plan.
34.23 Payments to the county-based purchasing plan for the period beginning July 1, 2010, and
34.24 ending July 1, 2011, shall be paid according to subdivision 10.

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

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

34.28 (2) provide a system for advocacy, consumer protection, and complaints and appeals
34.29 that is independent of care providers or other risk bearers and complies with section
34.30 256B.69;

34.31 (3) establish a process to monitor enrollment and ensure the quality of care provided;
34.32 and

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

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

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

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

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

35.10 Subd. 8. **Payments; fee-for-service rate for the period between March 1,**
35.11 **2010, and July 1, 2010.** (a) Effective for services provided on or after March 1, 2010,
35.12 and before July 1, 2010, the payment rates for all covered services provided to general
35.13 assistance medical care recipients, with the exception of outpatient prescription drug
35.14 coverage, shall be 50 percent of the general assistance medical care payment rate in effect
35.15 on February 28, 2010.

35.16 (b) Outpatient prescription drug coverage provided on or after March 1, 2010, and
35.17 before July 1, 2010, shall be paid on a fee-for-service basis in accordance with section
35.18 256B.0625, subdivision 13e.

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

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

35.26 (1) 69 percent of the general assistance medical care rate in effect on February
35.27 28, 2010, if the inpatient hospital services were provided in a hospital where the
35.28 fee-for-service inpatient and outpatient hospital general assistance medical care payments
35.29 to the hospital for admissions provided in calendar year 2007 totaled \$1,000,000 or more
35.30 or the hospital's fee-for-service inpatient and outpatient hospital general assistance medical
35.31 care payments received for calendar year 2007 admissions was one percent or more of the
35.32 hospital's net patient revenue received for services provided in calendar year 2007; or

35.33 (2) 60 percent of the general assistance medical care rate in effect on February 28,
35.34 2010, if the inpatient hospital services were provided by a hospital that does not meet the
35.35 criteria described in clause (1).

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

36.5 (d) Outpatient prescription drug coverage provided on or after July 1, 2010, and
36.6 before July 1, 2011, shall be paid on a fee-for-service basis in accordance with section
36.7 256B.0625, subdivision 13e.

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

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

36.22 (b) For each county that elects to provide services in accordance with subdivision
36.23 7, the commissioner shall determine a general assistance medical care county allocation
36.24 amount that equals the total general assistance medical care payments made for recipients
36.25 residing within the county in fiscal year 2009 for all covered general assistance medical
36.26 care services with the exception of outpatient prescription drug coverage.

36.27 (c) Outpatient prescription drug coverage provided on or after July 1, 2010,
36.28 and before July 1, 2011, shall be paid on a fee-for-service basis according to section
36.29 256B.0625, subdivision 13e.

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

36.32 Sec. 22. **[256D.032] GENERAL ASSISTANCE MEDICAL CARE ACCOUNT.**

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

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

37.2 Sec. 23. Minnesota Statutes 2008, section 256D.06, subdivision 7, is amended to read:

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

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

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

37.20 (d) Effective for general assistance medical care services rendered on or after
37.21 March 1, 2010, to June 30, 2011, any medical collections, payments, or recoveries under
37.22 this subdivision shall be deposited in or credited to the account established in section
37.23 256D.032.

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

37.25 Sec. 24. Minnesota Statutes 2008, section 256L.05, subdivision 1b, is amended to read:

37.26 Subd. 1b. **MinnesotaCare enrollment by county agencies.** Beginning September
37.27 1, 2006, county agencies shall enroll single adults and households with no children
37.28 formerly enrolled in general assistance medical care in MinnesotaCare according to
37.29 section 256D.03, subdivision 3, or 256D.031. County agencies shall perform all duties
37.30 necessary to administer the MinnesotaCare program ongoing for these enrollees, including
37.31 the redetermination of MinnesotaCare eligibility at renewal.

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

38.1 Sec. 25. Minnesota Statutes 2008, section 256L.05, subdivision 3, is amended to read:

38.2 Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the
38.3 first day of the month following the month in which eligibility is approved and the first
38.4 premium payment has been received. As provided in section 256B.057, coverage for
38.5 newborns is automatic from the date of birth and must be coordinated with other health
38.6 coverage. The effective date of coverage for eligible newly adoptive children added to a
38.7 family receiving covered health services is the month of placement. The effective date
38.8 of coverage for other new members added to the family is the first day of the month
38.9 following the month in which the change is reported. All eligibility criteria must be met
38.10 by the family at the time the new family member is added. The income of the new family
38.11 member is included with the family's gross income and the adjusted premium begins in
38.12 the month the new family member is added.

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

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

38.17 (d) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to
38.18 256L.18 are secondary to a plan of insurance or benefit program under which an eligible
38.19 person may have coverage and the commissioner shall use cost avoidance techniques to
38.20 ensure coordination of any other health coverage for eligible persons. The commissioner
38.21 shall identify eligible persons who may have coverage or benefits under other plans of
38.22 insurance or who become eligible for medical assistance.

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

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

38.28 Sec. 26. Minnesota Statutes 2008, section 256L.05, subdivision 3a, is amended to read:

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

38.32 (b) Each new period of eligibility must take into account any changes in
38.33 circumstances that impact eligibility and premium amount. An enrollee must provide all
38.34 the information needed to redetermine eligibility by the first day of the month that ends
38.35 the eligibility period. If there is no change in circumstances, the enrollee may renew

39.1 eligibility at designated locations that include community clinics and health care providers'
39.2 offices. The designated sites shall forward the renewal forms to the commissioner. The
39.3 commissioner may establish criteria and timelines for sites to forward applications to the
39.4 commissioner or county agencies. The premium for the new period of eligibility must be
39.5 received as provided in section 256L.06 in order for eligibility to continue.

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

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

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

39.16 Sec. 27. Minnesota Statutes 2008, section 256L.07, subdivision 6, is amended to read:

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

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

39.22 Sec. 28. Minnesota Statutes 2008, section 256L.15, subdivision 4, is amended to read:

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

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

39.29 Sec. 29. Minnesota Statutes 2008, section 256L.17, subdivision 7, is amended to read:

39.30 Subd. 7. **Exception for certain adults.** Single adults and households with
39.31 no children formerly enrolled in general assistance medical care and enrolled in

40.1 MinnesotaCare according to section 256D.03, subdivision 3, or 256D.031, are exempt
40.2 from the requirements of this section until renewal.

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

40.4 Sec. 30. **DRUG REBATE PROGRAM.**

40.5 The commissioner of human services shall continue to administer a drug rebate
40.6 program for drugs purchased for persons eligible for the general assistance medical care
40.7 program in accordance with Minnesota Statutes, sections 256.01, subdivision 2, paragraph
40.8 (cc), and 256D.03. The rebate revenues collected under the drug rebate program for
40.9 persons eligible for the general assistance medical care program shall be deposited in the
40.10 general assistance medical care account in the special revenue fund established under
40.11 Minnesota Statutes, section 256D.032.

40.12 **EFFECTIVE DATE.** This section is effective March 1, 2010, and expires June
40.13 30, 2011.

40.14 Sec. 31. **PROVIDER PARTICIPATION.**

40.15 For purposes of Minnesota Statutes, section 256B.0644, the reference to the general
40.16 assistance medical care program shall include the temporary general assistance medical
40.17 care program established under Minnesota Statutes, section 256D.031. In meeting the
40.18 requirements of Minnesota Statutes, section 256B.0644, a provider must accept new
40.19 patients regardless of the Minnesota health care program the patient is enrolled in and may
40.20 not refuse to accept patients enrolled in one Minnesota health care program and continue
40.21 to accept patients enrolled in other Minnesota health care programs.

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

40.23 Sec. 32. **TEMPORARY SUSPENSION.**

40.24 (a) For the period beginning March 1, 2010, to June 30, 2011, the commissioner
40.25 of human services shall not implement or administer Minnesota Statutes 2008, section
40.26 256D.03, subdivisions 6 and 9; Minnesota Statutes 2009 Supplement, section 256D.03,
40.27 subdivision 4; or Minnesota Statutes 2008, section 256B.692; and Minnesota Statutes
40.28 2009 Supplement, section 256B.69, as they apply to the general assistance medical care
40.29 program unless specifically continued in Minnesota Statutes, section 256D.031.

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

41.1 EFFECTIVE DATE. This section is effective March 1, 2010, and expires July 1,
41.2 2011.

41.3 Sec. 33. MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION
41.4 ASSESSMENT MODIFICATION; TRANSFER.

41.5 Subdivision 1. Minnesota Comprehensive Health Association assessment
41.6 modification. For the purpose of the annual assessment allocation required in Minnesota
41.7 Statutes, section 62E.11, the Minnesota Comprehensive Health Association shall credit
41.8 \$21,875,000 to HealthPartners' assessment for calendar year 2010 and \$13,125,000 to
41.9 HealthPartners' assessment for calendar year 2011, upon receipt by the association of the
41.10 transfers specified in subdivision 2.

41.11 Subd. 2. Transfer. \$21,875,000 shall be transferred in fiscal year 2011 and
41.12 \$13,125,000 in fiscal year 2012 from the general assistance medical care account
41.13 established in Minnesota Statutes, section 256D.032, to the commissioner of commerce
41.14 for disbursement upon receipt to the Minnesota Comprehensive Health Association, to
41.15 compensate for the loss in the association's assessments created by the credits specified in
41.16 subdivision 1.

41.17 **ARTICLE 2**

41.18 **APPROPRIATIONS**

41.19 Section 1. HEALTH AND HUMAN SERVICES APPROPRIATION.

41.20 The sums shown in the columns marked "Appropriations" are added to or, if shown
41.21 in parentheses, subtracted from the appropriations in Laws 2009, chapter 79, as amended
41.22 by Laws 2009, chapter 173, or other law to the agencies and for the purposes specified in
41.23 this article. The appropriations are from the general fund, or another named fund, and are
41.24 available for the fiscal years indicated for each purpose. The figures "2010" and "2011"
41.25 used in this article mean that the addition to or subtraction from appropriations listed under
41.26 them are available for the fiscal year ending June 30, 2010, or June 30, 2011, respectively.
41.27 "The first year" is fiscal year 2010. "The second year" is fiscal year 2011. "The biennium"
41.28 is fiscal years 2010 and 2011. Supplemental appropriations and reductions for the fiscal
41.29 year ending June 30, 2010, are effective the day following final enactment.

41.30 **APPROPRIATIONS**
41.31 **Available for the Year**
41.32 **Ending June 30**
41.33 **2010** **2011**

43.1	<u>Appropriations by Fund</u>		
43.2	<u>General</u>	<u>-0-</u>	<u>(4,070,000)</u>
43.3	<u>Special Revenue</u>	<u>3,074,000</u>	<u>57,945,000</u>
43.4	<u>(c) Medical Assistance Basic Health Care</u>		
43.5	<u>Grants - Elderly and Disabled</u>	<u>2,325,000</u>	<u>41,314,000</u>

43.6	<u>Appropriations by Fund</u>		
43.7	<u>General</u>	<u>-0-</u>	<u>(6,470,000)</u>
43.8	<u>Special Revenue</u>	<u>2,325,000</u>	<u>47,784,000</u>
43.9	<u>(d) General Assistance Medical Care Grants</u>	<u>(20,083,000)</u>	<u>266,945,000</u>

43.10	<u>Appropriations by Fund</u>		
43.11	<u>General</u>	<u>(60,406,000)</u>	<u>-0-</u>
43.12	<u>Special Revenue</u>	<u>40,323,000</u>	<u>266,945,000</u>

43.13 For general assistance medical care grants
 43.14 under Minnesota Statutes, section 256D.031.
 43.15 The commissioner shall transfer \$60,406,000
 43.16 on March 1, 2010, from the general fund to
 43.17 the fund established in Minnesota Statutes,
 43.18 section 256D.032. Any unexpended amount
 43.19 not used for general assistance medical care
 43.20 expenditures incurred before March 1, 2010,
 43.21 does not cancel and shall be transferred to
 43.22 the fund established in Minnesota Statutes,
 43.23 section 256D.032, by January 1, 2011.

43.24 **Subd. 5. Health Care Management**

43.25 The amounts that may be spent from the
 43.26 appropriation for each purpose are as follows:

43.27 **(a) Health Care Administration**

43.28	<u>Appropriations by Fund</u>		
43.29	<u>General</u>	<u>(825,000)</u>	<u>(2,425,000)</u>
43.30	<u>Special Revenue</u>	<u>825,000</u>	<u>2,784,000</u>

43.31 \$825,000 in fiscal year 2010 and \$2,475,000
 43.32 in fiscal year 2011 from the special revenue
 43.33 fund are for administration of the general
 43.34 assistance medical care program under
 43.35 Minnesota Statutes, section 256D.031. For

44.1 purposes of consistent cost allocation and
 44.2 accounting, the commissioner may transfer
 44.3 these amounts to the general fund. The
 44.4 commissioner shall transfer \$825,000 in
 44.5 fiscal year 2010 and \$2,475,000 in fiscal
 44.6 year 2011 from the general fund to the fund
 44.7 established in Minnesota Statutes, section
 44.8 256D.032.

44.9 **(b) Health Care Operations**

44.10	<u>Appropriations by Fund</u>		
44.11	<u>General</u>	<u>(1,025,000)</u>	<u>(3,075,000)</u>
44.12	<u>Special Revenue</u>	<u>1,067,000</u>	<u>3,075,000</u>

44.13 \$1,025,000 in fiscal year 2010 and
 44.14 \$3,075,000 in fiscal year 2011 from the
 44.15 special revenue fund are for operations of
 44.16 the general assistance medical care program
 44.17 under Minnesota Statutes, section 256D.031.

44.18 For purposes of consistent cost allocation
 44.19 and accounting, the commissioner may
 44.20 transfer these amounts to the general fund.
 44.21 The commissioner shall transfer \$1,025,000
 44.22 in fiscal year 2010 and \$3,075,000 in fiscal
 44.23 year 2011 from the general fund to the fund
 44.24 established in Minnesota Statutes, section
 44.25 256D.032.

44.26 **Subd. 6. Continuing Care Grants**

44.27	<u>Mental Health Grants</u>	<u>-0-</u>	<u>(5,000,000)</u>
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44.28 The commissioner shall reduce the amount
 44.29 allocated to adult mental health grants by
 44.30 \$5,000,000. This is a onetime reduction in
 44.31 fiscal year 2011. The commissioner shall
 44.32 transfer \$5,000,000 in fiscal year 2011 from
 44.33 the general fund to the fund established in
 44.34 Minnesota Statutes, section 256D.032.

45.1	<u>Subd. 7. Continuing Care Management</u>	<u>-0-</u>	<u>1,051,000</u>
45.2	<u>Subd. 8. Transfers</u>		
45.3	<u>(a) From March 1, 2010, until June 30, 2011,</u>		
45.4	<u>the commissioner may transfer amounts</u>		
45.5	<u>appropriated from the account created in</u>		
45.6	<u>Minnesota Statutes, section 256D.032, to the</u>		
45.7	<u>general fund to pay the hospital rate increases</u>		
45.8	<u>under Minnesota Statutes, section 256.969,</u>		
45.9	<u>from the medical assistance account.</u>		
45.10	<u>(b) From May 1, 2010, until June 30, 2011,</u>		
45.11	<u>the commissioner may transfer amounts</u>		
45.12	<u>appropriated from the account created in</u>		
45.13	<u>Minnesota Statutes, section 256D.032, to the</u>		
45.14	<u>general fund or the health care access fund</u>		
45.15	<u>to pay the managed care plan rate increases</u>		
45.16	<u>under Minnesota Statutes, section 256B.69,</u>		
45.17	<u>subdivision 5k, from the medical assistance</u>		
45.18	<u>account.</u>		
45.19	<u>EFFECTIVE DATE. This article is effective March 1, 2010.</u>		

APPENDIX
Article locations in s2168-1

ARTICLE 1 HEALTH CARE PROGRAM MODIFICATIONS Page.Ln 1.14
ARTICLE 2 APPROPRIATIONS Page.Ln 41.17