A bill for an act

relating to health care; establishing mental health urgent care and consultation services; modifying the general assistance medical care program; requiring a report; appropriating money; amending Minnesota Statutes 2008, sections 256.969, subdivision 27, by adding a subdivision; 256B.0625, subdivision 13f, by adding a subdivision; 256D.03, subdivisions 3a, 3b; 256D.06, subdivision 7; 256L.05, subdivisions 1b, 3, 3a; 256L.07, subdivision 6; 256L.15, subdivision 4; 256L.17, subdivision 7; Minnesota Statutes 2009 Supplement, sections 256.969, subdivisions 2b, 3a; 256B.196, subdivision 2; 256B.199; 256D.03, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 245; 256D.

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

ARTICLE 1

HEALTH CARE PROGRAM MODIFICATION

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

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

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

(a) Mental health urgent care includes:

(1) initial mental health screening;

(2) mobile crisis assessment and intervention;

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

(4) nonhospital crisis stabilization residential beds; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991. Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for

services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

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

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

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

(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, ~~2010~~ 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent

from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, ~~2010~~ 2011, to reflect this reduction.

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

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

Sec. 4. Minnesota Statutes 2008, section 256.969, is amended by adding a subdivision to read:

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

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

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

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

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

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

(d) The commissioner may adjust the intergovernmental transfers under paragraph (c) and the payments under paragraph (a) based on the commissioner's determination of Medicare upper payment limits, hospital-specific charge limits, and any limits imposed by the federal government regarding the rate increase or the restriction in the American Resource and Recovery Act, Public Law 111-5, regarding increased local share.

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

Sec. 5. Minnesota Statutes 2008, section 256.969, subdivision 27, is amended to read:

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

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

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

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

(4) in addition to any payments under clauses (1) to (3), for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance

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

(b) The state share of payments under paragraph (a) shall be equal to federal reimbursements to the commissioner to reimburse expenditures reported under section 256B.199, paragraphs (a) to (d). The commissioner shall ratably reduce or increase payments under this subdivision in order to ensure that these payments equal the amount of reimbursement received by the commissioner under section 256B.199, paragraphs (a) to (d), except that payments shall be ratably reduced by an amount equivalent to the state share of a four percent reduction in MinnesotaCare and medical assistance payments for inpatient hospital services. Effective July 1, 2009, the ratable reduction shall be equivalent to the state share of a three percent reduction in these payments. Effective for federal disproportionate share hospital funds earned on general assistance medical care payments for services rendered on or after March 1, 2010, to June 30, 2011, the amount of the three percent ratable reduction required under this paragraph shall be deposited in the account established in section 256D.032. Payments under this subdivision shall be further ratably reduced as follows: by $3,243,000 in fiscal year 2011; and by $2,495,000 in fiscal year 2012. These amounts shall be deposited in the account established in section 256D.032.

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

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

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

government, and otherwise adjust the provisions of this subdivision. The commissioner shall utilize a settlement process based on finalized data to maximize revenue under section 256B.199, paragraphs (a) to (d), and payments under this section.

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

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

Sec. 6. Minnesota Statutes 2008, section 256B.0625, subdivision 13f, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 7. Minnesota Statutes 2008, section 256B.0625, is amended by adding a subdivision to read:

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

(1) identify recommended pediatric dose ranges for atypical antipsychotic drugs and drugs used for attention deficit disorder or attention deficit hyperactivity disorder based on available medical, clinical, and safety data and research. The commissioner shall periodically review the list of medications and pediatric dose ranges and update

the medications and doses listed as needed after consultation with the Drug Utilization Review Board;

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

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

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

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

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

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

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

Sec. 8. Minnesota Statutes 2009 Supplement, section 256B.196, subdivision 2, is amended to read:

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

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

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

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

increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to Hennepin County Medical Center and Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph.

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

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

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

Sec. 9. Minnesota Statutes 2009 Supplement, section 256B.199, is amended to read:

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) The commissioner may adjust the intergovernmental transfers under paragraph (e) and the payments under paragraph (g) based on the commissioner's determination of Medicare upper payment limits, hospital-specific charge limits, and any limitations imposed by the federal government regarding the rate increase or the restriction in the American Resource and Recovery Act, Public Law 111-5, regarding increased local share.

(k) This section shall be implemented upon federal approval of the rate increase and a federal determination that the increased transfers do not violate the restriction in the American Resource and Recovery Act, Public Law 111-5, regarding the local share, retroactive to admissions occurring on or after July 15, 2010.

Sec. 10. Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, is amended to read:

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

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

(2) who is a resident of Minnesota; and

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

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

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

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

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

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

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

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

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

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

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

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

(6) are eligible under paragraph (k);

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

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

<u>If an enrollee meets one of the categories described in this paragraph, the commissioner shall not require the enrollee to enroll in MinnesotaCare.</u>

(g) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause

(2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization.

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

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

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

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

hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

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

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

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2008, section 256D.03, subdivision 3a, is amended to read:

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

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

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

Sec. 12. Minnesota Statutes 2008, section 256D.03, subdivision 3b, is amended to read:

Subd. 3b. **Cooperation.** (a) General assistance or general assistance medical care applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payors and assist the state in obtaining third-party payments. Cooperation includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. General assistance medical care applicants and recipients

must cooperate by providing information about any group health plan in which they may be eligible to enroll. They must cooperate with the state and local agency in determining if the plan is cost-effective. For purposes of this subdivision, coverage provided by the Minnesota Comprehensive Health Association under chapter 62E shall not be considered group health plan coverage or cost-effective by the state and local agency. If the plan is determined cost-effective and the premium will be paid by the state or local agency or is available at no cost to the person, they must enroll or remain enrolled in the group health plan. Cost-effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to subdivision 6.

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

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

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

Sec. 13. **[256D.031] GENERAL ASSISTANCE MEDICAL CARE.**

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

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

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

Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d,

except that the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum.

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 3. **Transitional MinnesotaCare.** (a) Except as provided in paragraph (c), effective March 1, 2010, all applicants and recipients who meet the eligibility requirements in subdivision 1, paragraph (a), clause (2), and who are not described in subdivision 2

shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, immediately following approval of general assistance medical care.

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

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

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

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

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

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

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

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

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

Subd. 4. **Eligibility and enrollment procedures.** (a) Eligibility for general assistance medical care shall begin no earlier than the date of application. The date of application shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules,

parts 9505.0015, subpart 5; and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

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

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

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

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

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

(2) outpatient hospital services;

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

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

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

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

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and x-ray services;

(10) physicians' services;

(11) medical transportation except special transportation;

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

(13) podiatric services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 6. **Coordinated care delivery option.** (a) A county or group of counties may elect to provide health care services to individuals who are eligible for general assistance medical care under this section and who reside within the county or counties through a coordinated care delivery option. The health care services provided by the county must include the services described in subdivision 5 with the exception of outpatient prescription drug coverage but including drugs administered in an outpatient setting. Counties that elect to provide health care services through this option must ensure that the requirements of this subdivision are met. Upon electing to provide services through this option, the county accepts the financial risk of the delivery of the health care services described in this subdivision to general assistance medical care recipients residing in

the county for the period beginning July 1, 2010, and ending July 1, 2011, for the fixed payments described in subdivision 10.

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

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

(2) the geographic area to be served.

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

(d) A county must demonstrate the ability to:

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

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

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

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

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

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

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

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

Subd. 8. **Payments; fee-for-service rate for the period between March 1, 2010, and July 1, 2010.** (a) Effective for services provided on or after March 1, 2010,

and before July 1, 2010, the payment rates for all covered services provided to general assistance medical care recipients, with the exception of outpatient prescription drug coverage, shall be 50 percent of the general assistance medical care payment rate in effect on February 28, 2010.

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

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

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

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

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

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

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

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

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

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

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

Subd. 11. **Veterans medical review team.** (a) To ensure the timely processing of determinations of service-connected disabilities among veterans enrolled in the temporary general assistance medical care program, the commissioner shall review all medical evidence submitted by enrollees with a referral and seek additional information from providers, applicants, and enrollees to support the determination of a service-connected disability when necessary. Service-connected disability shall be determined according to the regulations and policies of the United States Department of Veterans Affairs.

(b) Prior to a denial or withdrawal of a requested determination of service-connected disability due to insufficient evidence, the commissioner shall:

(1) ensure that the missing evidence is necessary and appropriate to a determination of service-connected disability; and

(2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

(c) The commissioner shall provide the chairs of the legislative committees with jurisdiction over health and human services finance and veterans affairs finance the following information on the activities of the veterans medical review team by August 1, 2010, and provide an update by January 1, 2011:

(1) the number of applications to the veterans medical review team that were denied, approved, or withdrawn;

(2) the average length of time from receipt of the application to a decision;

(3) the number of appeals and appeal results;

(4) for applicants, their age, health coverage at the time of application, hospitalization history within three months of application, and whether an application for service-connected veterans benefits is pending; and

(5) specific information on the medical certification, licensure, or other credentials of the person or persons performing the medical review determinations and length of time in that position.

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

Sec. 14. **[256D.032] GENERAL ASSISTANCE MEDICAL CARE ACCOUNT.**

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

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

Sec. 15. Minnesota Statutes 2008, section 256D.06, subdivision 7, is amended to read:

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

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

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

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

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

Sec. 16. Minnesota Statutes 2008, section 256L.05, subdivision 1b, is amended to read:

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

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

Sec. 17. Minnesota Statutes 2008, section 256L.05, subdivision 3, is amended to read:

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

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

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

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

shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

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

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

Sec. 18. Minnesota Statutes 2008, section 256L.05, subdivision 3a, is amended to read:

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

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

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

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

Sec. 19. Minnesota Statutes 2008, section 256L.07, subdivision 6, is amended to read:

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

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

Sec. 20. Minnesota Statutes 2008, section 256L.15, subdivision 4, is amended to read:

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

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

Sec. 21. Minnesota Statutes 2008, section 256L.17, subdivision 7, is amended to read:

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

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

Sec. 22. **DRUG REBATE PROGRAM.**

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

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

Sec. 23. **PROVIDER PARTICIPATION.**

For purposes of Minnesota Statutes, section 256B.0644, the reference to the general assistance medical care program shall include the temporary general assistance medical care program established under Minnesota Statutes, section 256D.031. In meeting the requirements of Minnesota Statutes, section 256B.0644, a provider must accept new patients regardless of the Minnesota health care program the patient is enrolled in and may

not refuse to accept patients enrolled in one Minnesota health care program and continue to accept patients enrolled in other Minnesota health care programs.

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

Sec. 24. **TEMPORARY SUSPENSION.**

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

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

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

Sec. 25. **COORDINATED CARE DELIVERY ORGANIZATION DEMONSTRATION PROJECT.**

The commissioner of human services shall develop, and present to the legislature by December 15, 2010, a plan to establish a demonstration project to deliver inpatient hospital, primary care, and specialist services to general assistance medical care enrollees through coordinated care delivery organizations, beginning January 1, 2012. Each coordinated care delivery organization must deliver coordinated care through at least one hospital and one physician group practice, and may include counties and other health care providers. The coordinated care delivery organization must provide inpatient hospital, primary care, and specialist services to general assistance medical care enrollees eligible for the program under Minnesota Statutes, section 256D.03 or 256D.031. The coordinated care delivery organization must accept responsibility for the quality of care and must assume financial risk for the services provided. The plan must include:

(1) financial incentives for coordinated care delivery organizations to reduce the growth in the volume and cost of services provided, while maintaining or improving the quality of care;

(2) recommendations for the delivery of services not provided through a coordinated care delivery organization and coordination of outpatient and inpatient health care services;

(3) recommendations as to the size and scope of the demonstration project and whether participation would be mandatory or voluntary for general assistance medical care enrollees; and

(4) recommendations for managing financial risk within a coordinated care delivery organization.

ARTICLE 2

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATION.**

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

	APPROPRIATIONS Available for the Year Ending June 30	
	2010	**2011**
Sec. 2. **HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ (88,580,000)**	**$ 27,041,000**
Appropriations by Fund		
	2010	2011
General	(62,256,000)	(34,866,000)
Health Care Access	(68,568,000)	(185,157,000)
Special Revenue	42,244,000	247,064,000
The amounts that may be spent for each purpose are specified in the following subdivisions.		
Subd. 2. **Children and Economic Assistance Grants**	-0-	(9,939,000)

The general fund appropriation to the commissioner of human services for children and community services grants in Laws 2009, chapter 79, article 13, section 3, subdivision 4, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 4, is reduced by $9,938,000 in fiscal year 2011. The general fund base for children and community service grants is increased by $9,938,000 per year for fiscal years 2012 and 2013.

Subd. 3. **Children and Economic Assistance Management**

Children and Economic Assistance Operations

	Appropriations by Fund	
Special Revenue	29,000	-0-

Subd. 4. **Basic Health Care Grants**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MinnesotaCare Grants	(68,569,000)	(185,157,000)
(b) Medical Assistance Basic Health Care Grants - Families and Children	-0-	(4,070,000)
(c) Medical Assistance Basic Health Care Grants - Elderly and Disabled	-0-	(6,470,000)

(d) General Assistance Medical Care Grants

	Appropriations by Fund	
General	(60,406,000)	-0-
Special Revenue	40,323,000	241,308,000

For general assistance medical care grants under Minnesota Statutes, section 256D.031. The commissioner shall transfer $60,406,000 on March 1, 2010, from the general fund to the fund established in Minnesota Statutes, section 256D.032. Any unexpended amount

not used for general assistance medical care expenditures incurred before March 1, 2010, does not cancel and shall be transferred to the fund established in Minnesota Statutes, section 256D.032, by January 1, 2011.

Subd. 5. **Health Care Management**

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

(a) Health Care Administration

	Appropriations by Fund	
General	(825,000)	(2,425,000)
Special Revenue	825,000	2,681,000

$825,000 in fiscal year 2010 and $2,475,000 in fiscal year 2011 from the special revenue fund are for administration of the general assistance medical care program under Minnesota Statutes, section 256D.031. For purposes of consistent cost allocation and accounting, the commissioner may transfer these amounts to the general fund. The commissioner shall transfer $825,000 in fiscal year 2010 and $2,475,000 in fiscal year 2011 from the general fund to the fund established in Minnesota Statutes, section 256D.032.

(b) Health Care Operations

	Appropriations by Fund	
General	(1,025,000)	(3,075,000)
Special Revenue	1,067,000	3,075,000

$1,025,000 in fiscal year 2010 and $3,075,000 in fiscal year 2011 from the special revenue fund are for operations of the general assistance medical care program under Minnesota Statutes, section 256D.031. For purposes of consistent cost allocation

and accounting, the commissioner may transfer these amounts to the general fund. The commissioner shall transfer $1,025,000 in fiscal year 2010 and $3,075,000 in fiscal year 2011 from the general fund to the fund established in Minnesota Statutes, section 256D.032.

Subd. 6. **Continuing Care Grants**

Mental Health Grants	-0-	(9,938,000)

The general fund appropriation to the commissioner of human services for adult mental health grants in Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, is reduced by $9,939,000 in fiscal year 2011. The general fund base for adult mental health grants is increased by $9,939,000 per year in fiscal years 2012 and 2013.

Subd. 7. **Continuing Care Management**	-0-	1,051,000

Subd. 8. **Transfers**

(a) The commissioner of management and budget shall transfer $168,733,000 in fiscal year 2011 and $12,979,000 in fiscal year 2012, from the general fund to the fund established in Minnesota Statutes, section 256D.032.

(b) $19,877,000 shall be transferred in fiscal year 2011 from the general fund to the general assistance medical care account established in Minnesota Statutes, section 256D.032.

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