256B.19 DIVISION OF COST.

Subdivision 1. **Division of cost.** The state and county share of medical assistance costs not paid by federal funds shall be as follows:

(1) beginning January 1, 1992, 50 percent state funds and 50 percent county funds for the cost of placement of severely emotionally disturbed children in regional treatment centers;

(2) beginning January 1, 2003, 80 percent state funds and 20 percent county funds for the costs of nursing facility placements of persons with disabilities under the age of 65 that have exceeded 90 days. This clause shall be subject to chapter 256G and shall not apply to placements in facilities not certified to participate in medical assistance;

(3) beginning July 1, 2004, 90 percent state funds and ten percent county funds for the costs of placements that have exceeded 90 days in intermediate care facilities for persons with developmental disabilities that have seven or more beds. This provision includes pass-through payments made under section 256B.5015; and

(4) beginning July 1, 2004, when state funds are used to pay for a nursing facility placement due to the facility's status as an institution for mental diseases (IMD), the county shall pay 20 percent of the nonfederal share of costs that have exceeded 90 days. This clause is subject to chapter 256G.

For counties that participate in a Medicaid demonstration project under sections 256B.69 and 256B.71, the division of the nonfederal share of medical assistance expenses for payments made to prepaid health plans or for payments made to health maintenance organizations in the form of prepaid capitation payments, this division of medical assistance expenses shall be 95 percent by the state and five percent by the county of financial responsibility.

In counties where prepaid health plans are under contract to the commissioner to provide services to medical assistance recipients, the cost of court ordered treatment ordered without consulting the prepaid health plan that does not include diagnostic evaluation, recommendation, and referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

Subd. 1a. [Repealed, 2002 c 277 s 34]

Subd. 1b. [Repealed, 1Sp2001 c 9 art 2 s 76]

Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall be responsible for a monthly transfer payment of $1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of $500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

(b) Beginning July 1, 2001, Hennepin County's payment under paragraph (a) shall be $2,066,000 each month.

(c) Beginning July 1, 2001, the commissioner shall increase annual capitation payments to the metropolitan health plan under section 256B.69 for the prepaid medical assistance program by approximately $6,800,000 to recognize higher than average medical education costs.

(d) Effective August 1, 2005, Hennepin County's payment under paragraphs (a) and (b) shall be reduced to $566,000, and the University of Minnesota's payment under paragraph (a) shall be

reduced to zero. Effective October 1, 2008, to December 31, 2010, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688. Effective January 1, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $566,000.

(e) Notwithstanding paragraph (d), upon federal enactment of an extension to June 30, 2011, of the enhanced federal medical assistance percentage (FMAP) originally provided under Public Law 111-5, for the six-month period from January 1, 2011, to June 30, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688.

Subd. 1d. [Repealed, 2009 c 79 art 8 s 86]

Subd. 1e. **Additional local share of certain nursing facility costs.** Beginning January 1, 2011, local government entities that own the physical plant or are the license holders of nursing facilities receiving rate adjustments under section 256B.441, subdivision 55a, shall be responsible for paying the portion of nonfederal costs calculated under section 256B.441, subdivision 55a, paragraph (d). Payments of the nonfederal share shall be made monthly to the commissioner in amounts determined in accordance with section 256B.441, subdivision 55a, paragraph (d). Payments for each month beginning in January 2011 through September 2015 shall be due by the 15th day of the following month. If any provider obligated to pay an amount under this subdivision is more than two months delinquent in the timely payment of the monthly installment, the commissioner may withhold payments, penalties, and interest in accordance with the methods outlined in section 256.9657, subdivision 7a.

[See Note.]

Subd. 2. **Distribution of federal funds.** Federal funds available for administrative purposes shall be distributed between the state and the county in the same proportion that expenditures were made, except as provided for in section 256.017.

Subd. 2a. **Division of costs.** The county shall ensure that only the least costly, most appropriate transportation and travel expenses are used. The state may enter into volume purchase contracts, or use a competitive bidding process, whenever feasible, to minimize the costs of transportation services. If the state has entered into a volume purchase contract or used the competitive bidding procedures of chapter 16C to arrange for transportation services, the county may be required to use such arrangements.

Subd. 2b. **Pilot project reimbursement.** In counties where a pilot or demonstration project is operated under the medical assistance program, the state may pay 100 percent of the administrative costs for the pilot or demonstration project after June 30, 1990.

Subd. 2c. **Obligation of local agency to investigate eligibility for medical assistance.** (a) When the commissioner receives information that indicates that a general assistance medical care recipient or MinnesotaCare program enrollee may be eligible for medical assistance, the commissioner may notify the appropriate local agency of that fact. The local agency must investigate eligibility for medical assistance and take appropriate action and notify the commissioner of that action within 90 days from the date notice is issued. If the person is eligible for medical assistance, the local agency must find eligibility retroactively to the date on which the person met all eligibility requirements.

(b) When a prepaid health plan under a contract with the state to provide medical assistance services notifies the commissioner that an infant has been or will be born to an enrollee under

the contract, the commissioner may notify the appropriate local agency of that fact. The local agency must investigate eligibility for medical assistance for the infant, take appropriate action, and notify the commissioner of that action within 90 days from the date notice is issued. If the infant would have been eligible on the date of birth, the local agency must establish eligibility retroactively to that month.

(c) For general assistance medical care recipients and MinnesotaCare program enrollees, if the local agency fails to comply with paragraph (a), the local agency is responsible for the entire cost of general assistance medical care or MinnesotaCare program services provided from the date the commissioner issues the notice until the date the local agency takes appropriate action on the case and notifies the commissioner of the action. For infants, if the local agency fails to comply with paragraph (b), the commissioner may determine eligibility for medical assistance for the infant for a period of two months, and the local agency shall be responsible for the entire cost of medical assistance services provided for that infant, in addition to a fee of $100 for processing the case. The commissioner shall deduct any obligation incurred under this paragraph from the amount due to the local agency under subdivision 1.

Subd. 3. **Study of medical assistance financial participation.** The commissioner shall study the feasibility and outcomes of implementing a variable medical assistance county financial participation rate for long-term care services to developmentally disabled persons in order to encourage the utilization of alternative services to long-term intermediate care for the developmentally disabled. The commissioner shall submit findings and recommendations to the legislature by January 20, 1984.

History: *Ex1967 c 16 s 19; 1971 c 547 s 1; 1975 c 437 art 2 s 7; 1982 c 640 s 7; 1983 c 312 art 9 s 6; 1984 c 534 s 24; 1Sp1985 c 9 art 2 s 46; 1986 c 444; 1987 c 403 art 2 s 85; 1988 c 719 art 8 s 16,17; 1Sp1989 c 1 art 16 s 8,9; 1990 c 568 art 3 s 64; 1991 c 292 art 4 s 51-53; 1992 c 513 art 7 s 82; 1993 c 13 art 1 s 32; 1Sp1993 c 1 art 5 s 84-86; 1995 c 207 art 6 s 82-84; 1995 c 234 art 8 s 56; 1997 c 203 art 11 s 7; 1998 c 386 art 2 s 80; 1Sp2001 c 9 art 2 s 45; 2002 c 220 art 14 s 7,8; 2002 c 277 s 20-23; 2002 c 375 art 2 s 34; 2002 c 379 art 1 s 113; 2003 c 9 s 1; 1Sp2003 c 14 art 3 s 43; 2005 c 56 s 1; 1Sp2005 c 4 art 2 s 14; art 8 s 48; 2008 c 363 art 15 s 8; 2010 c 396 s 4; 1Sp2010 c 1 art 24 s 6*

NOTE: Subdivision 1e, as added by Laws 2010, chapter 396, section 4, shall be implemented only upon federal approval. The commissioner of human services shall delay the effective date of subdivision 1e if necessary in order to avoid loss of enhanced federal Medicaid matching funds as authorized by the American Recovery and Reinvestment Act of 2009 and extended by any subsequent law. Laws 2010, chapter 396, section 9.