

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.

[See Note.]

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 the applicant's or recipient's 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.

[See Note.]

Subd. 3. 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 the noncitizen's 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.

(e) Applicants and recipients are eligible for general assistance medical care for a six-month eligibility period, unless a change that affects eligibility is reported. Eligibility may be renewed for additional six-month periods. During each six-month eligibility period, recipients who continue to meet the eligibility requirements of this section are not eligible for MinnesotaCare.

[See Note.]

Subd. 4. **General assistance medical care; services.** (a) Within the limitations described in this section, general assistance medical care covers medically necessary services that include:

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) services provided by Medicare-certified rehabilitation agencies;
- (4) prescription drugs;
- (5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;
- (6) eyeglasses and eye examinations;
- (7) hearing aids;
- (8) prosthetic devices, if not covered by veterans benefits;
- (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;
- (15) mental health services covered under chapter 256B;
- (16) 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;
- (17) 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;

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

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

(20) 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) Outpatient prescription drug coverage is covered in accordance with section 256D.03, subdivision 3.

(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, and \$1 per generic 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.

[See Note.]

Subd. 5. Payment rates and contract modification; April 1, 2010, to May 31, 2010. (a) For the period April 1, 2010, to May 31, 2010, general assistance medical care shall be paid on a fee-for-service basis. Fee-for-service payment rates for services other than outpatient prescription drugs shall be set at 37 percent of the payment rate in effect on March 31, 2010.

(b) Outpatient prescription drugs covered under section 256D.03, subdivision 3, provided on or after April 1, 2010, to May 31, 2010, shall be paid on a fee-for-service basis according to section 256B.0625, subdivisions 13 to 13g.

(c) If sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4, are implemented effective July 1, 2010:

(1) general assistance medical care must be paid on a fee-for-service basis for the period June 1 to June 30, 2010;

(2) fee-for-service payment rates for services other than outpatient prescription drugs must be set at 27 percent of the payment rate in effect on March 31, 2010; and

(3) outpatient prescription drugs considered under section 256D.03, subdivision 3, must be paid on a fee-for-service basis according to section 256B.0625, subdivisions 13 to 13g.

[See Note.]

Subd. 6. Coordinated care delivery systems. (a) Effective June 1, 2010, the commissioner shall contract with hospitals or groups of hospitals that qualify under paragraph (b) and agree to deliver services according to this subdivision. Contracting hospitals shall develop and implement a coordinated care delivery system to provide health care services to individuals who are eligible for general assistance medical care under this section and who either choose to receive services through the coordinated care delivery system or who are enrolled by the commissioner under paragraph (c). The health care services provided by the system must include: (1) the services described in subdivision 4 with the exception of outpatient prescription drug coverage but shall include drugs administered in a clinic or other outpatient setting; or (2) a set of comprehensive and medically necessary health services that the recipients might reasonably require to be maintained in good health and that has been approved by the commissioner, including at a minimum, but not limited to, emergency care, medical transportation services, inpatient hospital and physician care, outpatient health services, preventive health services, mental health services, and prescription drugs administered in a clinic or other outpatient setting. Outpatient prescription drug coverage is covered on a fee-for-service basis in accordance with section 256D.03, subdivision 3, and funded under subdivision 9. A hospital establishing a coordinated care delivery system under this subdivision must ensure that the requirements of this subdivision are met.

(b) A hospital or group of hospitals may contract with the commissioner to develop and implement a coordinated care delivery system as follows:

(1) effective June 1, 2010, a hospital qualifies under this subdivision if: (i) during calendar year 2008, it received fee-for-service payments for services to general assistance medical care recipients (A) equal to or greater than \$1,500,000, or (B) equal to or greater than 1.3 percent of net patient revenue; or (ii) a contract with the hospital is necessary to provide geographic access or to ensure that at least 80 percent of enrollees have access to a coordinated care delivery system; and

(2) effective December 1, 2010, a Minnesota hospital not qualified under clause (1) may contract with the commissioner under this subdivision if it agrees to satisfy the requirements of this subdivision.

Participation by hospitals shall become effective quarterly on June 1, September 1, December 1, or March 1. Hospital participation is effective for a period of 12 months and may be renewed for successive 12-month periods.

(c) Applicants and recipients may enroll in any available coordinated care delivery system statewide. If more than one coordinated care delivery system is available, the applicant or recipient shall be allowed to choose among the systems. The commissioner may assign an applicant or recipient to a coordinated care delivery system if no choice is made by the applicant or recipient. The commissioner shall consider a recipient's zip code, city of residence, county of residence, or distance from a participating coordinated care delivery system when determining default assignment. An applicant or recipient may decline enrollment in a coordinated care delivery system. Upon enrollment into a coordinated care delivery system, the recipient must agree to

receive all nonemergency services through the coordinated care delivery system. Enrollment in a coordinated care delivery system is for six months and may be renewed for additional six-month periods, except that initial enrollment is for six months or until the end of a recipient's period of general assistance medical care eligibility, whichever occurs first. A recipient who continues to meet the eligibility requirements of this section is not eligible to enroll in MinnesotaCare during a period of enrollment in a coordinated care delivery system. From June 1, 2010, to February 28, 2011, applicants and recipients not enrolled in a coordinated care delivery system may seek services from a hospital eligible for reimbursement under the temporary uncompensated care pool established under subdivision 8. After February 28, 2011, services are available only through a coordinated care delivery system.

(d) The hospital may contract and coordinate with providers and clinics for the delivery of services and shall contract with essential community providers as defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the extent practicable. If a provider or clinic contracts with a hospital to provide services through the coordinated care delivery system, the provider may not refuse to provide services to any recipient enrolled in the system, and payment for services shall be negotiated with the hospital and paid by the hospital from the system's allocation under subdivision 7.

(e) A coordinated care delivery system must:

(1) provide the covered services required under paragraph (a) to recipients enrolled in the coordinated care delivery system, and comply with the requirements of subdivision 4, paragraphs (b) to (g);

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

(3) in cooperation with counties, 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; and

(4) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(f) The hospital may require a recipient to designate a primary care provider or a primary care clinic. The hospital may limit the delivery of services to a network of providers who have contracted with the hospital to deliver services in accordance with this subdivision, and require a recipient to seek services only within this network. The hospital may also require a referral to a provider before the service is eligible for payment. A coordinated care delivery system is not required to provide payment to a provider who is not employed by or under contract with the system for services provided to a recipient enrolled in the system, except in cases of an emergency. For purposes of this section, emergency services are defined in accordance with Code of Federal Regulations, title 42, section 438.114 (a).

(g) A recipient enrolled in a coordinated care delivery system has the right to appeal to the commissioner according to section 256.045.

(h) The state shall not be liable for the payment of any cost or obligation incurred by the coordinated care delivery system.

(i) The hospital must provide the commissioner with data necessary for assessing enrollment, quality of care, cost, and utilization of services. Each hospital must provide, on a quarterly basis on

a form prescribed by the commissioner for each recipient served by the coordinated care delivery system, the services provided, the cost of services provided, and the actual payment amount for the services provided and any other information the commissioner deems necessary to claim federal Medicaid match. The commissioner must provide this data to the legislature on a quarterly basis.

(j) Effective June 1, 2010, the provisions of section 256.9695, subdivision 2, paragraph (b), do not apply to general assistance medical care provided under this section.

(k) Notwithstanding any other provision in this section to the contrary, for participation beginning September 1, 2010, the commissioner shall offer the same contract terms related to an enrollment threshold formula and financial liability protections to a hospital or group of hospitals qualified under this subdivision to develop and implement a coordinated care delivery system as those contained in the coordinated care delivery system contracts effective June 1, 2010.

(l) If sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4, are implemented effective July 1, 2010, this subdivision must not be implemented.

[See Note.]

Subd. 7. Payments; rate setting for the hospital coordinated care delivery system.

(a) Effective for general assistance medical care services, with the exception of outpatient prescription drug coverage, provided on or after June 1, 2010, through a coordinated care delivery system, the commissioner shall allocate the annual appropriation for the coordinated care delivery system to hospitals participating under subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1, 2010. The payment shall be allocated among all hospitals qualified to participate on the allocation date as follows:

(1) each hospital or group of hospitals shall be allocated an initial amount based on the hospital's or group of hospitals' pro rata share of calendar year 2008 payments for general assistance medical care services to all participating hospitals;

(2) the initial allocations to Hennepin County Medical Center; Regions Hospital; Saint Mary's Medical Center; and the University of Minnesota Medical Center, Fairview, shall be increased to 110 percent of the value determined in clause (1);

(3) the initial allocation to hospitals not listed in clause (2) shall be reduced a pro rata amount in order to keep the allocations within the limit of available appropriations; and

(4) the amounts determined under clauses (1) to (3) shall be allocated to participating hospitals.

The commissioner may prospectively reallocate payments to participating hospitals on a biannual basis to ensure that final allocations reflect actual coordinated care delivery system enrollment. The 2008 base year shall be updated by one calendar year each June 1, beginning June 1, 2011.

(b) Beginning June 1, 2010, and every quarter beginning in June thereafter, the commissioner shall make one-third of the quarterly payment in June and the remaining two-thirds of the quarterly payment in July to each participating hospital or group of hospitals.

(c) In order to be reimbursed under this section, nonhospital providers of health care services shall contract with one or more hospitals described in paragraph (a) to provide services to general assistance medical care recipients through the coordinated care delivery system established by the

hospital. The hospital shall reimburse bills submitted by nonhospital providers participating under this paragraph at a rate negotiated between the hospital and the nonhospital provider.

(d) The commissioner shall apply for federal matching funds under section 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

(e) Outpatient prescription drug coverage is provided in accordance with section 256D.03, subdivision 3, and paid on a fee-for-service basis under subdivision 9.

[See Note.]

Subd. 8. Temporary uncompensated care pool. (a) The commissioner shall establish a temporary uncompensated care pool, effective June 1, 2010. Payments from the pool must be distributed, within the limits of the available appropriation, to hospitals that are not part of a coordinated care delivery system established under subdivision 6.

(b) Hospitals seeking reimbursement from this pool must submit an invoice to the commissioner in a form prescribed by the commissioner for payment for services provided to an applicant or recipient not enrolled in a coordinated care delivery system. A payment amount, as calculated under current law, must be determined, but not paid, for each admission of or service provided to a general assistance medical care recipient on or after June 1, 2010, to February 28, 2011.

(c) The aggregated payment amounts for each hospital must be calculated as a percentage of the total calculated amount for all hospitals.

(d) Distributions from the uncompensated care pool for each hospital must be determined by multiplying the factor in paragraph (c) by the amount of money in the uncompensated care pool that is available for the six-month period.

(e) The commissioner shall apply for federal matching funds under section 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

(f) Outpatient prescription drugs are not eligible for payment under this subdivision.

[See Note.]

Subd. 9. Prescription drug pool. (a) The commissioner shall establish an outpatient prescription drug pool, effective June 1, 2010. Money in the pool must be used to reimburse pharmacies and other pharmacy service providers as defined in Minnesota Rules, part 9505.0340, for the covered outpatient prescription drugs dispensed to recipients. Payment for drugs shall be on a fee-for-service basis according to the rates established in section 256B.0625, subdivision 13e. Outpatient prescription drug coverage is subject to the availability of funds in the pool. If the commissioner forecasts that expenditures under this subdivision will exceed the appropriation for this purpose, the commissioner may bring recommendations to the Legislative Advisory Commission on methods to resolve the shortfall.

(b) Effective June 1, 2010, coordinated care delivery systems established under subdivision 6 shall pay to the commissioner, on a quarterly basis, an assessment equal to 20 percent of payments for the prescribed drugs for recipients of services through that coordinated care delivery system, as calculated by the commissioner based on the most recent available data.

[See Note.]

Subd. 10. **Assistance for veterans.** Hospitals participating in the coordinated care delivery system under subdivision 6 shall consult with counties, county veterans service officers, and the Veterans Administration to identify other programs for which general assistance medical care recipients enrolled in their system are qualified.

[See Note.]

History: 2010 c 200 art 1 s 12; 1Sp2010 c 1 art 16 s 32,40-42

NOTE: Subdivisions 1 to 10, as added by Laws 2010, chapter 200, article 1, section 12, and amended by Laws 2010, First Special Session chapter 1, article 16, sections 32, and 40 to 42, are repealed contingent upon implementation of Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4. Laws 2010, First Special Session chapter 1, article 16, section 47.