This Document can be made available
in alternative formats upon request

State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH SESSION

HOUSE FILE NO. 708

February 8, 2007
Authored by Thissen and Abeler
The bill was read for the first time and referred to the Committee on Health and Human Services

1.1 A bill for an act
1.2 relating to human services; requiring the commissioner of human services to
1.3 reimburse low-income Medicare enrollees for Medicare Part D cost-sharing and
1.4 out-of-pocket costs; modifying an ombudsman for managed care provision;
1.5 modifying a MnDHO provision; providing limited medical assistance coverage
1.6 for individuals eligible under Medicare Part D; appropriating money; amending
1.7 Minnesota Statutes 2006, sections 256B.031, subdivision 6; 256B.0625, by
1.8 adding a subdivision; 256B.69, subdivision 23; proposing coding for new law in
1.9 Minnesota Statutes, chapter 256.

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

1.11 Section 1. **[256.4765] MEDICARE PART D ASSISTANCE PROGRAM.**

1.12 The commissioner, by January 1, 2008, shall implement a program to reimburse
1.13 qualifying individuals for all costs incurred, above a $1,500 out-of-pocket limit, due to
1.14 Medicare Part D cost-sharing requirements and out-of-pocket expenditures made during
1.15 the coverage gap that occurs once the Medicare Part D initial coverage limit is reached.
1.16 For purposes of this subdivision, a qualifying individual is a person who:

1.17 (1) is enrolled in a Medicare Part D prescription drug plan;

1.18 (2) is not eligible for medical assistance; and

1.19 (3) has a household income that does not exceed 175 percent of the federal poverty
1.20 guidelines.

1.21 The commissioner shall calculate household income using the income methodology used
1.22 to determine medical assistance eligibility for persons who are aged, blind, or disabled.
1.23 The commissioner shall make information on this program available through health care
1.24 providers, pharmacies, senior citizen centers, and other sites, and shall publicize this
1.25 program through the Minnesota Board on Aging and the SeniorLinkage line.

2.1 Sec. 2. Minnesota Statutes 2006, section 256B.031, subdivision 6, is amended to read:
2.2 Subd. 6. **Ombudsman.** (a) The commissioner shall designate an ombudsman
2.3 to advocate for persons required to enroll in prepaid health plans under this section.
2.4 The ombudsman shall advocate for recipients enrolled in prepaid health plans through
2.5 complaint and appeal procedures and ensure that necessary medical services are provided
2.6 either by the prepaid health plan directly or by referral to appropriate social services. At
2.7 the time of enrollment in a prepaid health plan, and annually thereafter, the local agency
2.8 shall inform recipients about the ombudsman program and their right to a resolution of
2.9 a complaint by the prepaid health plan if they experience a problem with the plan or
2.10 its providers.
2.11 (b) The managed care ombudsman shall report annually to the house and senate
2.12 chairs of the committees having jurisdiction over health and human services on the budget
2.13 for and activities of the office, by program, age and eligibility type including the number
2.14 of persons assisted; the types of problems encountered; actions taken, including appeals;
2.15 outcomes for enrollees; and any recommendations for change to contracts, grievance, and
2.16 appeal process, or other changes to improve managed care services.

2.17 Sec. 3. Minnesota Statutes 2006, section 256B.0625, is amended by adding a
2.18 subdivision to read:
2.19 Subd. 13i. **Medicare Part D.** (a) Notwithstanding subdivision 13, paragraph (d),
2.20 for recipients who are enrolled in a Medicare Part D prescription drug plan or Medicare
2.21 Advantage special needs plan, medical assistance covers the following:
2.22 (1) co-payments which the recipient is responsible for under a Medicare Part D
2.23 prescription drug plan or Medicare Advantage special needs plan, once the recipient has
2.24 paid $12 per month in prescription drug co-payments, and according to the requirements
2.25 of the plan; and
2.26 (2) any prescription drug that is not covered by the Medicare Part D prescription
2.27 drug plan or Medicare Advantage special needs plan in which the recipient is enrolled
2.28 but only after a determination has been made by the Board on Aging that the recipient is
2.29 enrolled in the plan that provides the most comprehensive prescription drug coverage in
2.30 terms of the recipient's prescription drug needs.
2.31 (b) Notwithstanding subdivision 13, paragraph (d), for recipients who are eligible for
2.32 Medicare Part D but who are awaiting enrollment into a Medicare Part D prescription drug
2.33 plan or Medicare Advantage special needs plan, medical assistance covers prescription
2.34 drugs as required under subdivision 13, paragraph (a), for a period of 60 days beginning
2.35 the date the Medicare Part D application was submitted.

3.1 (c) Medical assistance coverage under paragraphs (a) and (b) shall be provided
3.2 according to the requirements of subdivisions 13 to 13h.

3.3 **EFFECTIVE DATE.** This section is effective July 1, 2007.

3.4 Sec. 4. Minnesota Statutes 2006, section 256B.69, subdivision 23, is amended to read:
3.5 Subd. 23. **Alternative services; elderly and disabled persons.** (a) The
3.6 commissioner may implement demonstration projects to create alternative integrated
3.7 delivery systems for acute and long-term care services to elderly persons and persons
3.8 with disabilities as defined in section 256B.77, subdivision 7a, that provide increased
3.9 coordination, improve access to quality services, and mitigate future cost increases.
3.10 The commissioner may seek federal authority to combine Medicare and Medicaid
3.11 capitation payments for the purpose of such demonstrations and may contract with
3.12 Medicare-approved special needs plans to provide Medicaid services. Medicare funds and
3.13 services shall be administered according to the terms and conditions of the federal contract
3.14 and demonstration provisions. For the purpose of administering medical assistance funds,
3.15 demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions
3.16 of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations,
3.17 with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1,
3.18 items B and C, which do not apply to persons enrolling in demonstrations under this
3.19 section. An initial open enrollment period may be provided. Persons who disenroll from
3.20 demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450
3.21 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and
3.22 the health plan's participation is subsequently terminated for any reason, the person shall
3.23 be provided an opportunity to select a new health plan and shall have the right to change
3.24 health plans within the first 60 days of enrollment in the second health plan. Persons
3.25 required to participate in health plans under this section who fail to make a choice of
3.26 health plan shall not be randomly assigned to health plans under these demonstrations.
3.27 Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220,
3.28 subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision,
3.29 the commissioner may contract with managed care organizations, including counties, to
3.30 serve only elderly persons eligible for medical assistance, elderly and disabled persons, or
3.31 disabled persons only. For persons with a primary diagnosis of developmental disability,
3.32 serious and persistent mental illness, or serious emotional disturbance, the commissioner
3.33 must ensure that the county authority has approved the demonstration and contracting
3.34 design. Enrollment in these projects for persons with disabilities shall be voluntary. The
3.35 commissioner shall not implement any demonstration project under this subdivision for

4.1 persons with a primary diagnosis of developmental disabilities, serious and persistent
4.2 mental illness, or serious emotional disturbance, without approval of the county board of
4.3 the county in which the demonstration is being implemented.

4.4 (b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501
4.5 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to
4.6 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement
4.7 under this section projects for persons with developmental disabilities. The commissioner
4.8 may capitate payments for ICF/MR services, waivered services for developmental
4.9 disabilities, including case management services, day training and habilitation and
4.10 alternative active treatment services, and other services as approved by the state and by the
4.11 federal government. Case management and active treatment must be individualized and
4.12 developed in accordance with a person-centered plan. Costs under these projects may not
4.13 exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003,
4.14 and until two years after the pilot project implementation date, subcontractor participation
4.15 in the long-term care developmental disability pilot is limited to a nonprofit long-term
4.16 care system providing ICF/MR services, home and community-based waiver services,
4.17 and in-home services to no more than 120 consumers with developmental disabilities in
4.18 Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature
4.19 prior to expansion of the developmental disability pilot project. This paragraph expires
4.20 two years after the implementation date of the pilot project.

4.21 (c) Before implementation of a demonstration project for disabled persons, the
4.22 commissioner must provide information to appropriate committees of the house of
4.23 representatives and senate and must involve representatives of affected disability groups
4.24 in the design of the demonstration projects.

4.25 (d) A nursing facility reimbursed under the alternative reimbursement methodology
4.26 in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity
4.27 provide services under paragraph (a). The commissioner shall amend the state plan and
4.28 seek any federal waivers necessary to implement this paragraph.

4.29 (e) The commissioner, in consultation with the commissioners of commerce and
4.30 health, may approve and implement programs for all-inclusive care for the elderly (PACE)
4.31 according to federal laws and regulations governing that program and state laws or rules
4.32 applicable to participating providers. The process for approval of these programs shall
4.33 begin only after the commissioner receives grant money in an amount sufficient to cover
4.34 the state share of the administrative and actuarial costs to implement the programs during
4.35 state fiscal years 2006 and 2007. Grant amounts for this purpose shall be deposited in an
4.36 account in the special revenue fund and are appropriated to the commissioner to be used

5.1 solely for the purpose of PACE administrative and actuarial costs. A PACE provider is
5.2 not required to be licensed or certified as a health plan company as defined in section
5.3 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county
5.4 and found to be eligible for services under the elderly waiver or community alternatives
5.5 for disabled individuals or who are already eligible for Medicaid but meet level of
5.6 care criteria for receipt of waiver services may choose to enroll in the PACE program.
5.7 Medicare and Medicaid services will be provided according to this subdivision and
5.8 federal Medicare and Medicaid requirements governing PACE providers and programs.
5.9 PACE enrollees will receive Medicaid home and community-based services through the
5.10 PACE provider as an alternative to services for which they would otherwise be eligible
5.11 through home and community-based waiver programs and Medicaid State Plan Services.
5.12 The commissioner shall establish Medicaid rates for PACE providers that do not exceed
5.13 costs that would have been incurred under fee-for-service or other relevant managed care
5.14 programs operated by the state.

5.15 (f) The commissioner shall seek federal approval to expand the Minnesota disability
5.16 health options (MnDHO) program established under this subdivision in stages, first to
5.17 regional population centers outside the seven-county metro area and then to all areas
5.18 of the state. Until ~~January 1, 2008~~ July 1, 2009, expansion for MnDHO projects that
5.19 include home and community-based services is limited to the two projects and service
5.20 areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that
5.21 include home and community-based services shall remain voluntary. Costs for home
5.22 and community-based services included under MnDHO must not exceed costs that
5.23 would have been incurred under the fee-for-service program. In developing program
5.24 specifications for expansion of integrated programs, the commissioner shall involve and
5.25 consult the state-level stakeholder group established in subdivision 28, paragraph (d),
5.26 including consultation on whether and how to include home and community-based waiver
5.27 programs. Plans for further expansion of MnDHO projects shall be presented to the chairs
5.28 of the house and senate committees with jurisdiction over health and human services
5.29 policy and finance by February 1, 2007.

5.30 (g) Notwithstanding section 256B.0261, health plans providing services under this
5.31 section are responsible for home care targeted case management and relocation targeted
5.32 case management. Services must be provided according to the terms of the waivers and
5.33 contracts approved by the federal government.

5.34 Sec. 5. **APPROPRIATION; OMBUDSMAN FOR MANAGED CARE.**

6.1 $300,000 is appropriated from the general fund to the commissioner of human
6.2 services for the biennium ending June 30, 2009, for the ombudsman for managed care
6.3 under Minnesota Statutes, section 256B.031, subdivision 6, to increase staff specifically
6.4 trained and experienced to assist persons with disabilities on issues involving health
6.5 coverage under Minnesota Statutes, section 256B.69. The federal Medicaid matching
6.6 funds available for this function shall be dedicated to the commissioner for this purpose.