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HOUSE FILE NO. 802

February 16, 2009
Authored by Murphy, E.
The bill was read for the first time and referred to the Committee on Health Care and Human Services Policy and Oversight
March 23, 2009
Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Finance
March 15, 2010
Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Ways and Means
March 18, 2010
Committee Recommendation and Adoption of Report:
To Pass as Amended
Read Second Time

A bill for an act

relating to human services; requiring mental health urgent care and psychiatric consultation; reducing certain hospital payment rates; changing medical assistance covered services; allowing intergovernmental transfers; creating a new general assistance medical care program; requiring coordinated care delivery systems; creating a temporary uncompensated care pool and prescription drug pool; appropriating money; amending Minnesota Statutes 2008, sections 256.969, subdivision 27; 256B.0625, subdivision 13f, by adding a subdivision; 256B.0644; 256B.69, subdivision 20; 256L.05, subdivisions 3, 3a, 3c; 517.08, subdivision 1c; Minnesota Statutes 2009 Supplement, sections 256.969, subdivision 3a; 256B.0947, subdivision 1; 256B.196, subdivision 2; 256D.03, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 245; 256B; 256D; repealing Minnesota Statutes 2008, sections 256.742; 256.979, subdivision 8; 256B.195, subdivisions 4, 5; 256D.03, subdivision 9; 256L.07, subdivision 6; 256L.15, subdivision 4; 256L.17, subdivision 7; Minnesota Statutes 2009 Supplement, sections 256B.195, subdivisions 1, 2, 3; 256D.03, subdivision 4.

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

ARTICLE 1

GENERAL ASSISTANCE MEDICAL CARE

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:

(1) mental health urgent care includes:

(i) initial mental health screening;

(ii) mobile crisis assessment and intervention;

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

(iv) nonhospital crisis stabilization residential beds; and

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

(2) 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 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 April 1, 2010.

Sec. 3. 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;

(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 payments reported under section 256B.199, paragraphs (a) to (d), for services rendered on or after April 1, 2010, payments shall not be made under this subdivision or subdivision 28.

(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 April 1, 2010.

Sec. 4. 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 April 1, 2010.

Sec. 5. 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 4.

Sec. 6. Minnesota Statutes 2008, section 256B.0644, is amended to read:

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

(1) the provider accepts new medical assistance, general assistance medical care, and MinnesotaCare patients;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage; or

(3) for dental service providers, at least ten percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other

neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of management and budget, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of management and budget shall implement this section through contracts with participating health and dental carriers.

(d) Any hospital or other provider that is participating in a coordinated care delivery system under section 256D.031, subdivision 6, or receives payments from the uncompensated care pool under section 256D.031, subdivision 8, shall not refuse to provide services to any patient enrolled in general assistance medical care regardless of the availability or the amount of payment.

(e) For purposes of paragraphs (a) and (b), participation in the general assistance medical care program applies only to pharmacy providers.

Sec. 7. Minnesota Statutes 2009 Supplement, section 256B.0947, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Effective November 1, ~~2010~~ 2011, and subject to federal approval, medical assistance covers medically necessary, intensive nonresidential rehabilitative mental health services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

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 60 days after federal approval.

Sec. 9. **[256B.197] INTERGOVERNMENTAL TRANSFERS; INPATIENT HOSPITAL PAYMENTS.**

Subdivision 1. **Federal approval required.** This section is effective for federal fiscal year 2010 and future years contingent on federal approval of the voluntary intergovernmental transfers and payments authorized under this section and contingent on payment of the intergovernmental transfers under this section.

Subd. 2. **Eligible nonstate government hospitals.** (a) Hennepin County Medical Center and Regions Hospital are eligible nonstate government hospitals.

(b) If the commissioner obtains federal approval to include other hospitals, including University of Minnesota Medical Center, Fairview, and SMDC Medical Center, the commissioner may expand the definition of eligible nonstate government hospitals to include other hospitals.

Subd. 3. **Commissioner's duties.** (a) For the purposes of this subdivision, the commissioner shall determine the fee-for-service inpatient hospital services upper

payment limit for nonstate government hospitals. The commissioner shall determine, for each eligible nonstate government hospital, the amount of a supplemental payment for inpatient hospital services that would increase medical assistance spending for each eligible nonstate government hospital up to the amount that Medicare would pay for the Medicaid fee-for-service inpatient hospital services provided by that hospital. If the combined amount of such supplemental payment amounts and existing medical assistance payments for inpatient hospital services to all nonstate government hospitals is less than the upper payment limit, the commissioner shall increase the supplemental payment amount for each eligible nonstate government hospital in proportion to the initial supplemental payments in order to maximize the additional total payments.

(b) The commissioner shall inform each eligible nonstate government hospital and associated governmental entities of voluntary intergovernmental transfers necessary to provide the nonfederal share for the supplemental payment amount attributable to each eligible nonstate government hospital, as calculated under paragraph (a).

(c) Upon receipt of a voluntary intergovernmental transfer from a governmental entity associated with an eligible nonstate government hospital or from the eligible nonstate government hospital, the commissioner shall make a supplemental payment, using the amounts calculated under paragraph (a), to the associated eligible nonstate government hospital.

(d) The commissioner may implement the payments in this section through use of periodic payments and voluntary intergovernmental transfers.

(e) The commissioner shall inform eligible nonstate government hospitals and associated governmental entities on an ongoing basis of the need for any changes needed in the payment amounts or voluntary intergovernmental transfers in order to continue the payments under paragraph (c) at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

Sec. 10. Minnesota Statutes 2008, section 256B.69, subdivision 20, is amended to read:

Subd. 20. **Ombudsperson.** The commissioner shall designate an ombudsperson to advocate for persons required to enroll in prepaid health plans under this section. The ombudsperson shall advocate for recipients enrolled in prepaid health plans through complaint and appeal procedures and ensure that necessary medical services are provided either by the prepaid health plan directly or by referral to appropriate social services. At the time of enrollment in a prepaid health plan, the local agency shall inform recipients about the ombudsperson program and their right to a resolution of a complaint by the prepaid health plan if they experience a problem with the plan or its providers.

(b) The commissioner shall designate an ombudsperson to advocate for persons enrolled in a coordinated care delivery system under section 256D.031, subdivision 6. The ombudsperson shall advocate for recipients enrolled in a coordinated care delivery system through the state appeal process, and assist enrollees in accessing necessary medical services through the coordinated care delivery system directly or by referral to appropriate services. At the time of enrollment in a coordinated care delivery system, the local agency shall inform recipients about the ombudsperson program.

Sec. 11. 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:~~ Beginning April 1, 2010, the general assistance medical care program shall be administered according to section 256D.031, unless otherwise stated, except for outpatient prescription drug coverage which shall continue to be administered under this section and funded under section 256D.031, subdivision 9, beginning June 1, 2010.

(b) Outpatient prescription drug coverage under general assistance medical care is limited to prescription drugs that:

(1) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(2) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with the agreements. Outpatient prescription drug coverage under general assistance medical care must conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13g.

(c) Outpatient prescription drug coverage does not include drugs administered in a clinic or other outpatient setting.

~~(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.~~

~~(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.~~

~~(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.~~

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

Sec. 12. **[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. **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.

(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.

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 veteran's 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.

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.

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 as 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 November 30, 2010, 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 November 30, 2010, 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 according to 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, 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.

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. Each hospital or group of hospitals shall receive a pro rata share of the allocation based on the hospital's or group of hospitals' calendar year 2008 payments for general assistance medical care services, provided that, for the purposes of this allocation, payments to Hennepin County Medical Center, Regions Hospital, and Fairview University Medical Center shall be weighted at 110 percent of the actual amount. 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) 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.

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

(d) Outpatient prescription drug coverage is provided according to section 256D.03, subdivision 3, and paid on a fee-for-service basis under subdivision 9.

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 November 30, 2010.

(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.

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.

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.

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

Sec. 13. 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, is the first day of the month following the last day of general assistance medical care coverage.~~

EFFECTIVE DATE. This section is effective January 1, 2011.

Sec. 14. 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, 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.

EFFECTIVE DATE. This section is effective January 1, 2011.

Sec. 15. Minnesota Statutes 2008, section 256L.05, subdivision 3c, is amended to read:

Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective date of coverage shall be the first day of the month following termination from medical assistance ~~or general assistance medical care~~ for families and individuals who are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance ~~or general assistance medical care~~. The applicant

must provide all required verifications within 30 days of the written request for verification. For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing. General assistance medical care recipients may qualify for retroactive coverage under this subdivision at a six-month renewal.

Sec. 16. Minnesota Statutes 2008, section 517.08, subdivision 1c, is amended to read:

Subd. 1c. **Disposition of license fee.** (a) Of the marriage license fee collected pursuant to subdivision 1b, paragraph (a), $25 must be retained by the county. The local registrar must pay $85 to the commissioner of management and budget to be deposited as follows:

(1) ~~$50~~ $55 in the general fund;

(2) $3 in the state government special revenue fund to be appropriated to the commissioner of public safety for parenting time centers under section 119A.37;

(3) $2 in the special revenue fund to be appropriated to the commissioner of health for developing and implementing the MN ENABL program under section 145.9255; and

(4) $25 in the special revenue fund is appropriated to the commissioner of employment and economic development for the displaced homemaker program under section 116L.96~~; and~~

~~(5) $5 in the special revenue fund is appropriated to the commissioner of human services for the Minnesota Healthy Marriage and Responsible Fatherhood Initiative under section 256.742~~.

(b) Of the $40 fee under subdivision 1b, paragraph (b), $25 must be retained by the county. The local registrar must pay $15 to the commissioner of management and budget to be deposited as follows:

(1) $5 as provided in paragraph (a), clauses (2) and (3); and

(2) $10 in the special revenue fund is appropriated to the commissioner of employment and economic development for the displaced homemaker program under section 116L.96.

~~(c) The increase in the marriage license fee under paragraph (a) provided for in Laws 2004, chapter 273, and disbursement of the increase in that fee to the special fund for the Minnesota Healthy Marriage and Responsible Fatherhood Initiative under paragraph (a), clause (5), is contingent upon the receipt of federal funding under United States Code, title 42, section 1315, for purposes of the initiative.~~

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

Sec. 17. **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.

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

Sec. 18. **TRANSITIONAL MINNESOTACARE PHASEOUT.**

For any applicant or recipient who meets the requirements of Minnesota Statutes, section 256D.03, subdivision 3, paragraph (d), before April 1, 2010, and who is not exempt under Minnesota Statutes, section 256D.03, subdivision 3, paragraph (f), the commissioner of human services shall continue the process of enrolling the recipient in MinnesotaCare as required under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), and, upon the completion of enrollment, the recipient shall receive services under MinnesotaCare in accordance with Minnesota Statutes, section 256L.03. County agencies shall continue to perform all duties necessary to administer the MinnesotaCare program ongoing for individuals enrolled in MinnesotaCare according to Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, paragraph (d), including the redetermination of MinnesotaCare eligibility at renewal.

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

Sec. 19. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall edit Minnesota Statutes, sections 256B.69 and 256B.692, to remove references to the general assistance medical care program.

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

Sec. 20. **REPEALER.**

(a) Minnesota Statutes 2008, sections 256.742; 256.979, subdivision 8; and 256D.03, subdivision 9, are repealed.

(b) Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, is repealed.

(c) Minnesota Statutes 2008, section 256B.195, subdivisions 4 and 5, are repealed effective retroactively to October 1, 2009.

(d) Minnesota Statutes 2009 Supplement, section 256B.195, subdivisions 1, 2, and 3, are repealed effective retroactively to October 1, 2009.

(e) Minnesota Statutes 2008, sections 256L.07, subdivision 6; 256L.15, subdivision 4; and 256L.17, subdivision 7, are repealed January 1, 2011.

ARTICLE 2

APPROPRIATIONS

Section 1. **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**	**$ (7,985,000)**	**$ (93,128,000)**
Appropriations by Fund		
	2010	2011
General	34,807,000	118,493,000
Health Care Access	(42,792,000)	(211,621,000)
The amounts that may be spent for each purpose are specified in the following subdivisions.		
Subd. 2. **Children Support Enforcement Grants**	-0-	(300,000)
Minnesota Healthy Marriage and Responsible Fatherhood Initiative Fee. Notwithstanding Minnesota Statutes, section 517.08, the balance and the fee revenue		

available to the commissioner of human services for the healthy marriage and responsible fatherhood initiative in the state government special revenue fund must be transferred to and deposited into the general fund by June 30, 2011.

Subd. 3. **Children and Economic Assistance Operations** (1,408,000) (1,560,000)

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

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

(a) **MinnesotaCare Grants** (42,792,000) (211,621,000)

This appropriation reduction is from the health care access fund.

(b) **Medical Assistance Basic Health Care Grants - Families and Children** -0- (49,000)

(c) **Medical Assistance Basic Health Care Grants - Elderly and Disabled** -0- (1,275,000)

(d) **General Assistance Medical Care** 39,413,000 135,837,000

For general assistance medical care payments under Minnesota Statutes, section 256D.031.

$5,500,000 in fiscal year 2010 and $65,500,000 in fiscal year 2011 is for payments to coordinated care delivery systems under Minnesota Statutes, section 256D.031, subdivision 7.

$4,375,000 in fiscal year 2010 and $51,875,000 in fiscal year 2011 is for payments for prescription drugs under Minnesota Statutes, section 256D.031, subdivision 9.

$28,000,000 in fiscal year 2010 is for provider and prescription drug payments

under Minnesota Statutes, section 256D.031, subdivision 5.

$1,538,000 in fiscal year 2010 and $18,462,000 in fiscal year 2011 is for payments from the temporary uncompensated care pool under Minnesota Statutes, section 256D.031, subdivision 8.

Any amount under paragraph (d) that is not spent in the first year does not cancel and is available for payments in the second year.

The commissioner may transfer any unexpended amount under Minnesota Statutes, section 256D.031, subdivision 9, after the final allocation in fiscal year 2011 to make payments under Minnesota Statutes, section 256D.031, subdivision 7.

Any unexpended amount not used for general assistance medical care expenditures incurred before April 1, 2010, under Minnesota Statutes, section 256D.03, shall be used to make payments under paragraph (d).

Subd. 5. **Health Care Management**

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

Health Care Administration	(2,998,000)	(5,270,000)

Base Adjustment. The general fund base for health care administration is reduced by $182,000 in fiscal year 2012 and $182,000 in fiscal year 2013.

Subd. 6. **Continuing Care Grants**

(a) Mental Health Grants	(200,000)	(7,904,000)

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 $7,704,000 in fiscal year 2011. This is a onetime reduction.

$200,000 of the reduction in each year is to eliminate specialty care grants for the 2007 mental health initiative infrastructure investments.

(b) Other Continuing Care Grants -0- (2,037,000)

HIV Grants. The general fund appropriation for the HIV drug and insurance grant program shall be reduced by $2,037,000 in fiscal year 2011 and increased by $2,037,000 in fiscal year 2013. These adjustments are onetime and must not be applied to the base. Notwithstanding any contrary provision, this provision expires June 30, 2013.

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

Subd. 8. **Transfers**

The commissioner must transfer $29,538,000 in fiscal year 2010 and $18,462,000 in fiscal year 2011 from the health care access fund to the general fund. This is a onetime transfer.

The commissioner must transfer $4,800,000 from the consolidated chemical dependency treatment fund to the general fund by June 30, 2010.

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

APPENDIX
Article locations in h0802-3

ARTICLE 1 GENERAL ASSISTANCE MEDICAL CARE ..... Page.Ln 1.19
ARTICLE 2 APPROPRIATIONS ..... Page.Ln 32.3

256.742 MINNESOTA HEALTHY MARRIAGE AND RESPONSIBLE FATHERHOOD INITIATIVE.

Subdivision 1. **Establishment.** Within the limits of available appropriations, the commissioner shall develop and implement a Minnesota Healthy Marriage and Responsible Fatherhood Initiative, as provided for in this section. The commissioner may administer the initiative with federal grants, state appropriations, and in-kind services received for this purpose.

Subd. 2. **Purpose.** The purpose of the Healthy Marriage and Responsible Fatherhood Initiative is to develop a community-based collaborative project that will test and evaluate a comprehensive strategy for promoting marriage and responsible fatherhood among unmarried urban parents who are expecting or have recently had a child. The initiative objectives are to:

(1) encourage stable family formation among unmarried new parents in urban communities;

(2) promote healthy marriages among unmarried new parents who want to be a couple and indicate that marriage is a goal for their relationship;

(3) increase paternity establishment and enhance related child support performance indicators;

(4) promote responsible fathering;

(5) enhance the well-being of children; and

(6) encourage and facilitate community support for marriage and family formation among unmarried parents.

Subd. 3. **Implementation.** The target population for the initiative is unmarried new parent couples whose babies are born in urban hospitals in Minneapolis and St. Paul. The initiative must not include couples with a history of domestic violence. In cases involving alcohol or substance abuse by either participant, the initiative must include the provision of resources and services to remedy those issues. The initiative may be implemented through the University of Minnesota and community-based programs and organizations. The commissioner shall:

(1) enter into contracts or manage a grant process for implementation of the initiative;

(2) provide technical assistance; and

(3) develop and implement an evaluation component for the initiative.

256.979 CHILD SUPPORT INCENTIVES.

Subd. 8. **Medical provider reimbursement.** (a) A fee to the providers of medical services is created for the purpose of increasing the numbers of signed and notarized recognition of parentage forms completed in the medical setting.

(b) A fee of $25 shall be paid to each medical provider for each properly completed recognition of parentage form sent to the Department of Vital Statistics.

(c) The Office of the State Registrar shall notify the Department of Human Services quarterly of the numbers of completed forms received and the amounts paid.

(d) The Department of Human Services shall remit quarterly to each medical provider a payment for the number of signed recognition of parentage forms completed by that medical provider and sent to the Office of the State Registrar.

(e) The commissioners of the Department of Human Services and the Department of Health shall develop procedures for the implementation of this provision.

(f) Payments will be made to the medical provider within the limit of available appropriations.

(g) Federal matching funds received as reimbursement for the costs of the medical provider reimbursement must be retained by the commissioner of human services for educational programs dedicated to the benefits of paternity establishment.

256B.195 INTERGOVERNMENTAL TRANSFERS; HOSPITAL PAYMENTS.

Subdivision 1. **Federal approval required.** Section 145.9268 and this section are contingent on federal approval of the intergovernmental transfers and payments to safety net hospitals and community clinics authorized under this section. These sections are also contingent on current payment, by the government entities, of intergovernmental transfers under section 256B.19 and this section.

Subd. 2. **Payments from governmental entities.** (a) In addition to any payment required under section 256B.19, effective July 15, 2001, the following government entities shall make the payments indicated annually:

(1) Hennepin County, $24,000,000; and

(2) Ramsey County, $12,000,000.

(b) These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs. Of these payments, Hennepin County shall pay 71 percent directly to Hennepin County Medical Center, and Ramsey County shall pay 71 percent directly to Regions Hospital. The counties must provide certification to the commissioner of payments to hospitals under this subdivision.

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

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

(2) to Regions Hospital, any federal matching funds available to match the payments received by the hospital under subdivision 2, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care.

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

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

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

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

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

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

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

(e) Effective July 1, 2003, if the amount available for allocation under paragraph (b) is greater than the amounts available during March 2003, after any increase in intergovernmental transfers and payments that result from section 256.969, subdivision 3a, paragraph (c), are paid to the general fund, any additional amounts available under this subdivision after reimbursement of the transfers under subdivision 2 shall be allocated to increase medical assistance payments, subject to hospital-specific charge limits and limits on disproportionate share hospital payments, as follows:

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

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

Subd. 4. **Adjustments permitted.** (a) The commissioner may adjust the intergovernmental transfers under subdivision 2 and the payments under subdivision 3, and payments and transfers under subdivision 5, based on the commissioner's determination of Medicare upper payment limits, hospital-specific charge limits, and hospital-specific limitations on disproportionate share payments. Any adjustments must be made on a proportional basis. If participation by a particular hospital under this section is limited, the commissioner shall adjust the payments that relate to that hospital under subdivisions 2, 3, and 5 on a proportional basis in order to allow the hospital to participate under this section to the fullest extent possible and shall increase other payments under subdivisions 2, 3, and 5 to the extent allowable to maintain the overall level of payments under this section. The commissioner may make adjustments under this subdivision only after consultation with the counties and hospitals identified in subdivisions 2 and 3, and, if subdivision 5 receives federal approval, with the hospital and educational institution identified in subdivision 5.

(b) The ratio of medical assistance payments specified in subdivision 3 to the intergovernmental transfers specified in subdivision 2 shall not be reduced except as provided under paragraph (a).

Subd. 5. **Inclusion of Fairview University Medical Center.** (a) Upon federal approval of the payments in paragraph (b), the commissioner shall establish an intergovernmental transfer with the University of Minnesota in an amount determined by the commissioner based on the amount of Medicare upper payment limit available for nongovernment hospitals adjusted by hospital-specific charge limits and the amount available under the hospital-specific disproportionate share limit.

(b) Effective July 1, 2003, the commissioner shall increase payments for medical assistance admissions at Fairview University Medical Center by 71 percent of the transfer plus any federal matching payments on that amount, to increase payments for medical assistance admissions and to recognize higher medical assistance costs in institutions that provide high levels of charity care. Twenty-nine percent of the transfer plus federal matching funds available as a result of the transfers in subdivision 5 shall be paid to the largest ten percent of hospitals in the nongovernment hospital category as measured by 2001 payments for medical assistance, general assistance medical care, and MinnesotaCare. Payments shall be allocated according to each hospital's proportionate share of the 2001 payments. The commissioner shall determine which hospitals are in the nongovernment hospital category.

256D.03 RESPONSIBILITY TO PROVIDE GENERAL ASSISTANCE.

Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(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) physician's 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.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) Effective August 1, 2005, sex reassignment surgery is not covered under this subdivision.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Effective January 1, 2008, drug coverage under general assistance medical care is limited to prescription drugs that:

(i) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(ii) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with the agreements. Prescription drug coverage under general assistance medical care must conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13g.

(e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following co-payments for services provided on or after October 1, 2003, and before January 1, 2009:

(1) $25 for eyeglasses;

(2) $25 for nonemergency visits to a hospital-based emergency room;

(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(4) 50 percent coinsurance on restorative dental services.

(f) Recipients eligible under subdivision 3, paragraph (a), shall include the following co-payments for services provided on or after January 1, 2009:

(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.

(g) MS 2007 Supp [Expired]

(h) Effective January 1, 2009, 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. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $7 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

(i) General assistance medical care reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of the co-payments effective January 1, 2009.

(j) Any county may, from its own resources, provide medical payments for which state payments are not made.

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

(l) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(m) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

(n) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (l).

(o) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

(p) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

(q) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

(r) Fee-for-service payments for nonpreventive visits shall be reduced by $3 for services provided on or after January 1, 2006. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse, audiologist, optician, or optometrist.

(s) Payments to managed care plans shall not be increased as a result of the removal of the $3 nonpreventive visit co-payment effective January 1, 2006.

(t) Payments for mental health services added as covered benefits after December 31, 2007, are not subject to the reductions in paragraphs (l), (n), (o), and (p).

(u) Effective for services provided on or after July 1, 2009, total payment rates for basic care services shall be reduced by three percent, in accordance with section 256B.766. Payments made to managed care plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

(v) Effective for services provided on or after July 1, 2009, payment rates for physician and professional services shall be reduced as described under section 256B.76, subdivision 1, paragraph (c). Payments made to managed care and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

Subd. 9. **Payment for ambulance services.** Effective for services rendered on or after July 1, 1999, general assistance medical care payments for ambulance services shall be increased by five percent.

256L.07 ELIGIBILITY FOR MINNESOTACARE.

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, are eligible without meeting the requirements of this section until renewal.

256L.15 PREMIUMS.

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, until six-month renewal. The county agency has the option of continuing to pay premiums for these enrollees.

256L.17 ASSET REQUIREMENT FOR MINNESOTACARE.

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, are exempt from the requirements of this section until renewal.